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ANNUAL REPORT

OF THE

Principal School Medical Officer

FOR THE YEAR

1958

GEORGE G. STEWART, M.R.C.S., L.R.C.P., D.P.H.
PRINCIPAL SCHOOL MEDICAL OFFICER

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THE SPECIAL SERVICES SUB-COMMITTEE OF THE EDUCATION COMMITTEE—1958

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* Ex-officio member.

PREFACE

COUNTY HALL,
CHELMSFORD.
June, 1960

To the Chairman and Members of the Education Committee.

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my Annual Report as Principal School Medical Officer for the year 1958 : pressure of work and difficulties in the filling of senior appointments in the Health Department have delayed its publication and this is regretted.

The Report of the Principal School Dental Officer (Mr. J. Byrom, L.D.S.) on pages 51 to 55 inclusive clearly indicates the parlous state of the School Dental Service. In particular, your attention is drawn to the further reduction in the number of dental officers employed (the equivalent of 36.2 whole-time dentists as compared with 39.4 at the end of 1957) and the lower ratio of permanent teeth filled to the number extracted due to dental disease viz 4.6 : 1 (5.1 : 1 in 1957 and 5.5 : 1 in 1956). This is, of course, a National problem and sooner or later it will have to be tackled at the highest possible level.

The statistical information given in Appendix A on pages 56 to 63 inclusive is required by the Ministry of Education.

As a result of the National campaign for the immunisation of all children, Diphtheria is now an uncommon disease. However, the epidemic which occurred in Barking during the Autumn of 1958 (which is reported upon in full by Dr. F. Groarke, Medical Officer of Health and Divisional School Medical Officer, in Appendix D on pages 75 to 81 inclusive) and caused the first death from Diphtheria in the Administrative County for ten years, is a sharp reminder that it is still vitally necessary for every child to receive this valuable protection against a deadly disease.

Attention is also drawn to the experimental work which is being undertaken in the North-East Essex and Forest Divisions in regard to various alternatives for the second (intermediate) routine medical inspection of pupils, details of which are given on pages 12 to 14 and also in the special Report by Dr. R. E. Barrett, School Medical Officer, which is published in Appendix C, pages 71 to 74.

Once again I would like to place on record my thanks to Members of the Education Committee for the support and assistance which they have given to me during the year, to the Chief Education Officer and his staff for their willing co-operation in all matters relating to the School Health Service and to my own staff, both in the Divisions and in the Central Office, for their continued loyalty.

I am, Ladies and Gentlemen,
Your obedient Servant,
GEO. G. STEWART,
Principal School Medical Officer.

County Council of Essex

STAFF OF THE SCHOOL HEALTH SERVICE

(*as at* 31*st December*, 1958)

CENTRAL OFFICE

Principal School Medical Officer:
GEORGE G. STEWART, M.R.C.S., L.R.C.P., D.P.H.

Deputy Principal School Medical Officer:
J. A. C. FRANKLIN, M.B., B.S., D.P.H.

Senior Medical Officer (Child Health):
T. K. WHITMORE, M.R.C.S., L.R.C.P., D.C.H.

Principal School Dental Officer:
J. BYROM, L.D.S.

DIVISIONAL STAFFS

North-East Essex Educational Division

MEDICAL OFFICERS

Divisional School Medical Officer:
* JOHN D. KERSHAW, M.D., B.S., D.P.H.

School Medical Officers:
ANN B. CLARK, M.R.C.S., L.R.C.P.
* R. E. BARRETT, M.B., B.S., M.R.C.S., L.R.C.P., D.T.M. & H., D.P.H.
* E. A. HARGREAVES, M.R.C.S., L.R.C.P., D.P.H.
* J. HARKNESS, M.B. Ch. B.
* J. R. HETHERINGTON, L.R.C.P. & S., L.R.F.P.S., D.P.H.
SYLVIA I. E. MACMILLAN, M.B., B.S., D.P.H.
* R. D. PEARCE, M.R.C.S., L.R.C.P., D.P.H.
ELEANOR M. SINGER, M.Sc., M.R.C.S., L.R.C.P., D.C.H.

In addition, there were four Medical Officers undertaking 11 sessions a week on a sessional basis.

DENTAL OFFICERS

* J. F. GODFREY, L.D.S.
D. J. HEARNS, B.D.S.

In addition, there were five Dental Officers undertaking 15 sessions a week on a sessional basis.

* *Part-time Officer*

Mid-Essex Educational Division

MEDICAL OFFICERS

Divisional School Medical Officer:
* J. L. Miller Wood, V.R.D., M.R.C.S., L.R.C.P., D.P.H.

School Medical Officers:
* T. D. Blott, B.Sc., M.B., B.S., D.P.H.
Joyce W. Brown, M.B., Ch.B., D.P.H.
Deidre R. Dooley, L.R.C.P. & S., D.C.H.
I. G. P. Fraser, M.B., Ch.B., D.P.H.
* Irene M. Conway Hastilow, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H., D.C.H., D.Obst., R.C.O.G.
Muriel Parkes, B.A., M.B., B.Ch., B.A.O.
* C. R. C. Rainsford, M.D., D.P.H., D.T.M.
Margaret Turner, M.R.C.S., L.R.C.P.
Annette Wyatt, M.D., B.S., M.R.C.S., L.R.C.P.

DENTAL OFFICERS

B. G. Brown, L.D.S.
Mrs. N. S. Mezits, Dental Doctor, Latvia

In addition, there were four Dental Officers undertaking 20 sessions a week on a sessional basis.

South-East Essex Educational Division

MEDICAL OFFICERS

Divisional School Medical Officer:
* W. J. Moffat, M.B., Ch.B., D.P.H.

School Medical Officers:
Jean Buchanan, M.B., Ch.B.
J. C. T. Fiddes, M.B., Ch.B.
T. H. J. Hardgreaves, M.R.C.S., L.R.C.P.
* P. X. O'Dwyer, M.B., B.Ch., D.P.H.
J. Reach, M.D. (Prague)
Jean Troughton, L.R.C.P. & S.

DENTAL OFFICERS

H. J. Cracknell, L.D.S.
R. Maxwell, L.D.S.
* H. L. Thorn, L.D.S.

In addition, there were seven Dental Officers undertaking 19 sessions per week on a sessional basis.

* *Part-time Officer*

South Essex Educational Division

MEDICAL OFFICERS

Divisional School Medical Officer:
* W. T. G. Boul, M.B.E., M.D., D.P.H., F.Z.S.

School Medical Officers:
Elizabeth M. Hardgreaves, M.B., Ch.B., D.P.H.
W. R. Howell, L.M.S.S.A.
* D. T. Jones, B.Sc., M.B., B.Ch.
(Commenced 15.3.58)
Muriel M. Lingwood, M.B., B.S.
(Commenced 1.8.58)
* T. Mackinnell-Childs, M.R.C.S., L.R.C.P., M.B., B.Ch., B.A., D.P.H.
R. G. Newberry, M.B., B.S.
* P. J. Roden, L.M.S.S.A.
Mary M. E. Rutter, M.R.C.S., L.R.C.P., M.B., B.S., D.C.H., M.D., D.P.H.
Aniela A. Szwede, M.B., Ch.B.
Doris E. C. Walker, M.B., B.S., L.R.C.P., M.R.C.S., D.A.
Mair E. Williams, M.R.C.S., L.R.C.P.

DENTAL OFFICERS

R. A. Collins, L.D.S.
Mrs. C. Grieshaber, Doctor Medicinal Dentium, Berlin University
Mrs. O. Saunders, Diploma of Dental Surgery, Latvia

In addition, there was one Dental Officer undertaking one session a week on a sessional basis.

Forest Educational Division

MEDICAL OFFICERS

Divisional School Medical Officer:
* F. G. Brown, T.D., M.B., B.Ch., B.A.O., D.P.H.

School Medical Officers:
* I. Ash, M.D. (Rome), D.P.H.
* J. H. Crosby, M.B., Ch.B., D.P.H.
Gisella Eisner, M.D. (Prague), D.C.H.
* H. Franks, M.B., B.S., B.Hy., D.P.H.
J. T. Jones, M.B., B.Ch.
(Commenced 11.8.58)
Elizabeth Vaughan, M.R.C.S., L.R.C.P.
(Commenced 17.3.58)
Lily White, M.B., Ch.B.

DENTAL OFFICERS

Mrs. L. E. Broadbent, L.D.S.
Mrs. E. Kimelman, M.D. (Vienna)

In addition, there were eight Dental Officers undertaking 22 sessions a week on a sessional basis.

* *Part-time Officer*

Romford Educational Division

MEDICAL OFFICERS

Divisional School Medical Officer:
* James B. Samson, M.D., Ch.B., D.P.H.

School Medical Officers:
J. J. Duffy, M.B., B. Ch., B.A.O., D.P.H.
Elizabeth M. Haga, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.
Sylvia R. Ingold, M.B., B.S., M.R.C.S., L.R.C.P., D.Obst. R.C.O.G.
N. P. Bhandari, M.B., B.S., M.R.C.S., L.R.C.P., C.P.H.

DENTAL OFFICERS

Miss M. L. Ell, L.D.S.

In addition, there were two Dental Officers undertaking 9 sessions a week on a sessional basis.

Barking Educational Division

MEDICAL OFFICERS

Divisional School Medical Officer:
*F. L. Groake, M.B., L.M., D.C.H., D.P.H.

School Medical Officers:
* Margaret I. Adamson, M.B., Ch.B., D.P.H.
Eileen E. Martin, M.B., Ch.B.
Eugenia Popper, M.D. (Vienna)
Violet Spiller, M.D. (Geneva), M.R.C.S., L.R.C.P., D.P.H.
Mary H. Westlake, M.B., Ch.B., D.P.H

DENTAL OFFICERS

J. Buntin, L.D.S.

In addition, there were two Dental Officers undertaking 9 sessions a week on a sessional basis.

Dagenham Educational Division

MEDICAL OFFICERS

Divisional School Medical Officer:
* J. Adrian Gillet, M.B., Ch.B., D.P.H.

School Medical Officers:
Catherine Fitzpatrick, M.B., B.Ch.
Fannie Hirst, M.B., Ch.B., D.P.H.
E. P. James, M.R.C.S., L.R.C.P., L.M.S.S.A., D.Obst.R.C.O.G.
Wilhelmina C. Maguire, L.M., L.R.C.P., L.R.C.S.I.
* Helen E. Mair, M.B., Ch.B., D.P.H.
Madeline Weizmann, M.R.C.S., L.R.C.P.

In addition, there was one Medical Officer undertaking one session each week on a sessional basis.

* *Part-time Officer*

DENTAL OFFICERS

There were five Dental Officers undertaking 12 sessions a week on a sessional basis.

Ilford Educational Division

MEDICAL OFFICERS

Divisional School Medical Officer:

* I. GORDON, M.D., Ch.B., M.R.C.P., D.P.H.

School Medical Officers:

ANNIE COLLINS, M.B., B.Ch., B.A.O.

FRANCES E. O'CONNOR-WILSON, B.A., M.B., B.Ch., B.A.O., D.P.H., L.M.

* HELEN B. GRANGE, M.B., B.S.

* DESIREE M. B. GROSS, M.D., Ch.B., M.M.S.A., D.P.H.

R. M. NOORDIN, M.R.C.S., L.R.C.P.

DENTAL OFFICERS

Senior Dental Officer:

E. V. HAIGH, L.D.S.

In addition, there were seven Dental Officers undertaking 21 sessions a week on a sessional basis.

Leyton Educational Division

MEDICAL OFFICERS

Divisional School Medical Officer:

* M. WATKINS, M.R.C.S., L.R.C.P., D.P.H.

School Medical Officers:

ETHEL R. EMSLIE, M.D., Ch.B., D.P.H., D.C.H.

* MARY L. GILCHRIST, M.D., Ch.B., D.P.H.

ELSIE JAIKARAN, M.B., B.S., M.R.C.S., L.R.C.P., M.R.C.O.G.
(Commenced 30.6.58)

ELSIE L. PEET, M.D., M.B., L.D.S.

In addition, there was one Medical Officer undertaking three sessions a week on a sessional basis.

DENTAL OFFICERS

Senior Dental Officer:

A. E. HALL, L.D.S.

Dental Officer:

T. D. H. MILLAR, L.D.S., R.C.S.

In addition, there were four Dental Officers undertaking nine sessions a week on a sessional basis.

* *Part-time Officer*

Walthamstow Educational Division

MEDICAL OFFICERS

Divisional School Medical Officer:
* A. T. W. Powell, M.C., M.B., D.S., D.P.H.

School Medical Officers:
Carmel P. Dooley, L.R.C.P. & S., D.P.H.
* Margaret Edwards, M.B., B.Ch., C.P.H.
* Joycelyn H. Newman, M.B., Ch.B., D.Obst.R.C.O.G., D.P.H.
* Geoffrey Poole, M.B., B.S., D.Obst.R.C.O.G., D.P.H.
Josephine P. Werren, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H., D.Obst.R.C.O.G.

DENTAL OFFICERS

Miss D. Anklesaria, L.D.S.
R. E. Hyman, L.D.S.
G. P. L. Taylor, L.D.S.
J. Timmis, L.D.S.

In addition, there were three Dental Officers undertaking 12 sessions a week on a sessional basis.

SCHOOL NURSING STAFF, MEDICAL AUXILIARIES AND DENTAL ATTENDANTS

	Number employed	*Aggregate of time give to School Health Servi (in terms of whole-tim officers)*
Health Visitor/School Nurses	197	104.97
School Nurses only	60	
Nursing Assistants	41	17.05
Dental Attendants	53	41.36
Speech Therapists	27	22.30
Oral Hygienists	1	0.64
Psychiatric Social Workers	14	11.32
Physiotherapists	1	1.0
Chiropodists	9	0.82
Occupational Therapists	1	1.0

* *Part-time Officer*

GENERAL INFORMATION

The Registrar-General's estimate of population for the Administrative County at mid-year 1958 was 1,783,000, of whom approximately 281,800 were children of school age.

School Population.

Divisional Executive	1958			1951
	Primary Schools	*Secondary Schools*	*Total*	*Total*
North East	15,351	11,700	27,051	23,366
Mid-Essex	19,355	12,648	32,003	26,037
South East	15,317	9,399	24,716	13,340
South Essex	29,212	18,656	47,868	29,375
Forest	23,386	15,137	38,523	27,911
Romford	13,718	8,730	22,448	12,806
Dagenham	11,242	9,417	20,659	19,407
Barking	6,875	5,610	12,485	12,506
Ilford	13,980	9,740	23,720	72,218
Leyton	6,544	6,326	12,870	12,810
Walthamstow	9,490	9,967	19,457	18,738
Total 1958	164,470	117,330	281,800	
Total 1957	174,342	102,702	277,044	
Total 1951	141,893	76,621	218,514	

chools

	1958		1951
Nursery Schools	3		3
Primary Schools	718		624
Secondary (including grammar schools and technical colleges)	212		169
Special Schools for :			
Deaf children	1		1
Partially-sighted children	1		1
E.S.N. children	9	(including 2 residential)	5
E.S.N./Maladjusted children	1	(residential)	—
Maladjusted children	2	(residential)	—
Physically handicapped and/or Delicate children	6	(including 1 residential)	6
Cerebral-palsied children	1		—

A—ASSESSMENT OF HEALTH

Medical Inspection

Arrangements have continued for pupils to be examined on entry to school, during their last year at the primary school and just before leaving school, and 73,383 children were examined in 1958 in these age groups.

Compared with 1957 rather more children were found at routine medical inspections to have defects requiring medical treatment, the number being 11,295, i.e., 17.3% of children inspected. The percentage figures for previous years are compared in Table 1 below :—

Table 1—Percentage of children seen at routine periodic medical inspections who require treatment

Year	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958
Percentage	21.8	20.7	20.6	19.3	20.8	17.7	17.2	17.1	15.7	17.3

From the particulars set out in Table B on page 57 of pupils found to require treatment at periodic medical inspections, it will be seen that the great majority of these defects were discovered for the first time at these inspections.

Reference was made in my report last year to an experimental break with the traditional intermediate inspection conducted in the North-East Essex Division : in the selected schools the routine intermediate inspection has been replaced by a system of more frequent " screening " inspections by nurses and the examination by the school medical officers of children noted in these " screening " inspections, or by the teachers and parents, as having signs of possible defects. The two schools selected for this experiment were St. George's and St. John's Green Junior Schools in Colchester. There were slight differences in the procedure used in the two schools, that at St. George's School relying to a greater extent on formal screening inspections by the nurses whilst at St. John's Green School the medical officer made more frequent visits for discussion with the teachers.

A report on a year's working of the experiment is to be found in Appendix C on page 71 by Dr. R. E. Barrett, one of the School Medical Officers concerned. Commenting upon the report of this experiment, Dr. Kershaw, Divisional School Medical Officer, states :—

> " It would be premature to draw definite conclusions from the first year's working of the new procedure, but I am certainly impressed by its possibilities. I have the impression that defects were detected earlier and, therefore, at a more tractable stage than by the standard routine

procedures and I have no reason to believe that defects which routine inspections would have discovered have been missed. Both Dr. Barrett and Dr. Macmillan found the teachers interested and report that though at the beginning there was a tendency for them to notify trivial obvious defects, as the year went on they became more discriminating and were bringing forward children with less obvious and more important defects. I have long felt that the teacher, who sees the child daily, has a great potential part to play as an observer in the School Health Service and it seems that in these schools the invitation to the teachers to take a responsible part and the readiness of the medical officers to visit the schools and discuss the problems of the children who have been referred has developed willing and understanding co-operation.

I am not yet completely convinced that the routine inspection of the " intermediate " group is without virtue. The experiment has been debated hotly at staff conferences during the year and some medical officers feel that in abandoning the routine inspection we might lose something of great value in the chance it gives for the school medical officer to meet and talk with the children's parents. The question of whether the new procedure saves time is still debatable. Dr. Macmillan's technique certainly saved the medical officer's time without greatly increasing the time spent by the school nurses, and her results, in terms of defects found, were comparable with those obtained by routine inspection as well as with those of Dr. Barrett, who gave a greater proportion of his own time to school visits, but much depends on circumstances and personalities and what can be achieved by one particular doctor and nurse at one particular school would not necessarily apply to another doctor and another nurse at another school.

It is unfortunate that Dr. Barrett's departure for work with the World Health Organisation will interrupt the experiment at St. John's Green School, but Dr. Macmillan will continue at St. George's and I am hoping that two other school medical officers will try similar experiments at other schools in the Division, outside Colchester. There is no doubt that experience to date shows that the innovation is worthy of a further and more extensive trial."

With the approval of the Ministry of Education, a similar experiment commenced at the beginning of the Autumn term on a considerably larger scale in the Urban District of Harlow, in the Forest Division, where all the schools are visited by one or other of two school medical officers. Dr. F. G. Brown, Divisional School Medical Officer, reports :—

" Experience in this Division during the past few years has shown that in Harlow, the defects noted by the Medical Officer at the second routine medical inspection of pupils (10-12 year age group) were, in the majority of instances, already known to the parent and in most cases being treated by the general practitioner. It was therefore felt that routine inspection of all pupils in this age group was unnecessary and time-wasting, and an alternative scheme was proposed, the basis of which is that the school medical officer and school nurse visit each school twice every term to confer with the Head Teacher and, if necessary, the class teacher, about any child whom they think ought to be examined. At this meeting, registers are perused and a note is made to examine those who have records of absence on medical grounds. Arrangements are then made for the examination of the children concerned and the parents invited to be present. No child is examined without the knowledge of the parents. This scheme commenced in the Autumn term and, in the first instance, is for a trial period of one year."

At the same time, in another part of the Forest Division, a further variation was made with regard to the intermediate routine medical inspection. Dr. Brown reports :—

" In the Chigwell Urban District and the Borough of Wanstead and Woodford, instead of dispensing with the second routine inspection which, in the past, has been carried out during the pupil's last year in the primary school, it is undertaken after admission to the secondary school. There are divergent views as to whether the best time to carry out the second routine inspection is in the primary or the secondary school. There is something to be said in favour of either arrangement ; in the primary school, the teachers who have had the child for three or four years are in a position to offer useful information to the medical officer. In the secondary school, little is known about the pupil but, as the medical inspection is unlikely to take place within six months of the child's admission, sufficient time has elapsed to observe whether he/she appears to have a physical defect."

All these experiments are continuing.

Physical Conditions of Pupils

It will be seen from the figures in Table A on page 56 that during 1958 only 1 per cent. of the children examined were found to be " unsatisfactory " and that this was less common in children over the age of 12.

It would clearly be of interest to know the extent to which the children classified as " unsatisfactory " eventually attain a " satisfactory " physical condition. No figures are available to demonstrate this but in practice such children are carefully followed up. Dr. M. Watkins, Divisional School Medical Officer for Leyton, for example, describes his arrangements in this respect as follows :—

"When a child is placed in this category the procedure followed depends upon the cause of the failure in health. Any one, or a combination of the following actions will be carried out :—

I. The mother is advised as to treatment and
   (a) the child will be followed up after some weeks by attendance at the School Clinic, or
   (b) the child will be seen during the Spring term by the health visitor and school medical officer at a school re-inspection.

II. Referred to the Clinic within a few days for further investigation if the cause of the child's "unsatisfactory" condition is not immediately apparent.

III. Referred to the private doctor and followed up later at the Clinic or school re-inspection.

IV. Referred to Hospital with the consent of the general practitioner and again followed up.

V. If the parent is not present at the inspection, the health visitor will visit the home or the parent will be sent an invitation to attend at the Clinic or school on another date.

No record has been kept as to when these children are taken off the "unsatisfactory" list but they are followed up until the condition causing the placement in this category has been dealt with."

Cleanliness Inspections

In 1958 there were 251 more children found to be infested with vermin than in 1957 (Table D. page 57), giving a rate of 0.32 per 100 children inspected. This is the first year that this incidence has not shown a fall since figures were available in 1950 (see Table 2, below).

Table 2—Infestation rates amongst school children

	1950	1951	1952	1953	1954	1955	1956	1957	1958
No. of children infested with vermin per 100 inspected	1.1	0.92	0.67	0.55	0.42	0.32	0.28	0.24	0.32

At the same time, fewer individual inspections of pupils were made, 510,489, compared with 568,660.

Procedure for carrying out cleanliness inspections vary slightly in the Divisions. Children in infant and junior schools are normally inspected at the beginning of each term; children in secondary modern, grammar and technical schools are commonly inspected once a year.

Mortality among school children.

For the first time this year an analysis of the cause of deaths of children of school age is included in Appendix B on page 64. It will be seen that the greatest number of deaths occur among school children as a result of accidents, from respiratory infections, leukaemia and aleukaemia and malignant new growths. The number of boys killed as a result of accidents of all kinds is striking and largely accounts for the greater mortality of this sex.

The year 1958 is significant in that a school child died from diphtheria for the first time in ten years and another school child died from complicated chickenpox. The diphtheria death which is referred to again on page 75 in Appendix D, occurred during an outbreak of diphtheria in Barking.

B.—PROMOTION OF HEALTH AND PREVENTION OF INFECTION

Health Education.

Health education continues to be one of the best ways of promoting the health of school children and the School Health Service staff throughout the year have devoted a large part of their work to this service. As stated in my Report last year, much more work of this type needs to be done and during the course of the year under review a considerable expansion has taken place. An innovation started during the year was the " School Health Week," designed to " spot light " over a period of a week in the school one particular aspect of Health Education. Examples of subjects dealt with were, Foot Health, Dental Health and Home Safety.

School Meals Service.

I am indebted to the Chief Education Officer for the following report by the Organiser of the School Meals Service :—

> " The number of school children having meals on a typical day in the Autumn term 1958 was 130,060. This figure, which represented 49.5 per cent of the school attendance, was an increase of 2.8 per cent over the previous year. The actual number of meals served was one of the highest recorded.
>
> Children are attending secondary schools in ever increasing numbers and the percentage staying for meals in these schools is very high, especially in grammar and technical schools. Considerable attention is being paid to the service of meals in secondary schools as the particular requirements and demands of the older school children are difficult to meet within the limits of cost and food allowances laid down by the Ministry of Education.
>
> The charge for a school dinner to day pupils at maintained schools (1/-d.) remained unchanged during the year.
>
> Thirty new school kitchens were opened during the year and at eight existing schools either new kitchens or extensive improvements were provided ".

Many of the improvements referred to are the result of compliance with The Food Hygiene Regulations 1955.

Physical Education.

The Chief Education Officer has also submitted the following report by Miss B. M. Rains and Mr. H. P. Crabtree, the Senior Organisers of Physical Education :—

> " Inter-school competitions and rallies in all forms of physical education continue to be keenly supported. These lead to Divisional competitions and the formation of County teams. National successes in some of these sports deserve especial mention.
>
> **Athletics.**—At the English Schools National Athletic Championships held in Durham the Essex Senior boys' team were champions of England and the Intermediate girls' team were runners up. Out of 42 counties competing, Essex was fifth in the aggregate points.
>
> **Swimming.**—In October at the Schools National Swimming Gala held in Rochdale, Essex children won the diving trophy for the highest aggregate points. Pat Baines of Ilford was national champion for breast stroke, and Brian Phelps of East Ham national diving champion.
>
> In the summer of 1958 the first covered school swimming bath (in lieu of a second gymnasium) since the war was completed and opened. This is the first of several more which are in the planning stage.
>
> **Boxing.**—The English Schools Boxing Championships of Great Britain were held at Brighton in March and Essex boys won six national championships, two 12–13 years, one 13–14 years, and three 14–15 years. These champions came from Upton Park, Romford, Braintree, Barking and Stratford. In addition there were three finalists. Two Essex boys represented England v. Wales at Bristol and six boxed for the South of England v. The North.
>
> **Cricket.**—Essex County Schools Cricket Association selected the Essex XI which played five matches and were undefeated. These matches were played against Kent (won), Middlesex (won), Suffolk (drawn in winning position), Sussex (drawn), Kent (drawn in losing position). The boys forming the XI were drawn from eight of the eleven County divisions, and East and West Ham.
>
> **Dancing.**—Another honour for Essex in 1958 was that the boys and girls from Dury Falls Secondary School, Hornchurch, were invited to demonstrate National and Folk Dancing at the Annual Conference of the British Association of Organisers and Lecturers in Physical Education. Twenty-four fourth-year boys and girls travelled to Eastbourne and, dressed in colourful costumes made at the school, gave a spirited and most successful display of dances from England, Scotland and Europe.

Football.—Football continues to be one of the most popular sports, and the various County trophies were competed for with the usual enthusiasm. Many more schools are now playing both Soccer and Rugby and the South-East Division again held their annual 7 a side competitions for secondary modern schools. This was won by Wickford competing against much larger schools.

Camping and Sailing.—Camping sites and canvas were again widely used and sailing and boat building in schools is very rapidly increasing. In January of this year there was formed an Essex Schools Sailing Association, which already has membership from schools in all areas of the County. It is proposed in the future to hold sailing courses and sailing galas.

Courses for Teachers.—Courses for teachers have been held in most Divisions of the County in a wide variety of subjects. One Saturday in May a one-day course was held at the South-East Essex Technical College for men and women specialists in secondary schools. In spite of the 'bus strike almost one hundred teachers travelled from all parts of Essex. The course was opened by the Chief Education Officer who with the Principal of the College, spent the day watching the various activities. Lt. Col. Heald addressed the whole course on the Duke of Edinburgh's award for boys and Miss Hubbard, Headmistress of Warwick Secondary School for Girls, Walthamstow, one of the schools selected in the Pilot Scheme, spoke on the award for girls. After luncheon the teachers split into groups to take part in Tennis, Swimming and Trampolining, and after tea came together again for a final session of National Dancing.

Keep Fit.—Throughout the winter, a successful course was held training housewives to be instructors in Evening Institutes and Youth Clubs. Many of the trainees are now in charge of classes.

A second Women's Keep Fit Association, the South Essex K.F.A., has been formed amongst classes in Brentwood, Romford, Hornchurch, Grays, Dagenham, Barking and Ilford. Over 400 women class members accompanied by their instructors, met together to take part in some mass keep fit exercises, and dancing at the South-East Essex Technical College on a November Saturday afternoon.

County Show.—Once more demonstrations of gymnastics and dancing were given by boys and girls from secondary schools in a large marquee at the County Show in June. Despite the many attractions of the Show, a large number of people came into the tent to watch.

Congratulations and appreciation are again due to the teachers for the good work they are doing in Essex."

Convalescence

During the year arrangements have continued whereby children are sent for convalescence. The number of children sent from each Division is set out in Table 3 on this page. It will be seen that nearly twice as many children sent were from the urban areas as compared with children from the rural areas.

Table 3—Children sent for convalescence

Divisional Executive	*Sent for convalescence*	
North East	22	184
Mid Essex	39	
South East	20	
South Essex	70	
Forest	33	
Romford	55	342
Dagenham	71	
Barking	77	
Ilford	32	
Leyton	50	
Walthamstow	57	

Preventive Chiropody

During 1958 all the children at one secondary school and about half those at another were seen by the chiropodist. In all 1,924 children in the 11-15 age group (991 girls and 933 boys) were seen and of this number 177 (9.2 per cent.) had foot defects. No fewer than 90 per cent. of the cases in this category were girls.

In reporting on this work, the chiropodist undertaking these duties made the following comments :—

> " The contrast between the boys' and the girls' feet was most marked. Although both sexes presented normal feet at the age of 11 and 12, girls had, by age 14, developed a considerable variety of minor deformities, the commonest being postural pes valgus and degrees of hallux valgus and hammer toes. The boys presented few deformities at any age that required treatment.
>
> The main reason for the progressive deterioration of the girls' feet from the age of 11 mentioned above was the wearing of shoes that made it impossible for a correct fitting or size to be achieved. Because the majority of girls wear a casual shoe that has no means of remaining in position except by constriction at the toes, it is obviously impossible to have a shoe of either sufficient length or width. The essence of good shoe-fitting is some form of attachment over the instep, this allows for a large space in the area of the toe-box.
>
> I feel that some sort of postural training is needed for the secondary modern girls. By this I mean an attempt to get the girls in the habit

of constantly holding themselves erect. The general sloppy posture of the majority of the girls has led to poor muscle tone and consequent disorders of the feet."

At present children referred from any source can attend foot clinics held in Health Services Clinics in Laindon, Hornchurch, Brentwood and in Barking, Dagenham, Leyton and Walthamstow. In Walthamstow there is one session a week solely for children. In the remaining Divisions of the County there are no special facilities for chiropody and this is a matter which is receiving attention, particularly as the demand in these areas is at present an unknown quantity.

Prevention of Diphtheria

The percentage of school-children immunised against Diphtheria during the last five years is set out below :—

Table 4

1954	1955	1956	1957	1958
43.0	41.3	40.5	39.3	39.5

Prevention of Tuberculosis

The downward trend in the notification rates of tuberculosis among children aged 5-14 years has continued, whilst that among the adolescent group has levelled off. Table 5 below demonstrates this :—

Table 5—Notifications of Tuberculosis 1950-58

Age Range	1950	1951	1952	1953	1954	1955	1956	1957	1958
5-14 years	143	122	115	146	98	83	73	74	49
15-19 years	181	160	143	124	132	97	99	64	68

The details of children offered and undergoing B.C.G. vaccination during 1958 are given in a table on page 65. The scheme for B.C.G. vaccination of school children in their fourteenth year has continued. The standard fresh fluid vaccine manufactured in Denmark has been used throughout the County save in the Forest Division, where from June onwards freeze-dried vaccine was used experimentally.

Other preventive measures include the chest x-ray of staff in the schools in close contact with the children.

Poliomyelitis.

There was no major outbreak of poliomyelitis among school children during the year under review and notifications were accordingly very low.

Table 6—Notification of Poliomyelitis 1956-58
(Children aged 5-14 years)

	1956	1957	1958
Non-paralytic	27	69	16
Paralytic	17	94	12
Total	44	153	28
Deaths	2	2	—

It is too soon yet to draw any conclusion as to the extent to which vaccination has contributed generally to the reduction of the incidence of poliomyelitis.

Other Infectious Diseases.

An outbreak of Sonne Dysentery occurred in a school in the Forest Division and Dr. Brown, Divisional School Medical Officer, reports :—

> " On the 15th May the head teacher of a primary (junior) school reported that 32 children and 8 members of the staff were suffering from sickness and diarrhoea. In conjunction with officers of the Public Health Department of Chigwell Urban District Council, an immediate investigation was commenced to find the cause of the illness. A meat pie provided for the mid-day meal two days previously was suspected and pathological tests of a sample of the pie confirmed that the germ of Sonne Dysentery found in a portion of the meat was responsible for the outbreak. In the meantime, the number of persons affected rose rapidly and within a few days more than 200 cases had been notified. The school canteen had been closed and remained closed for a period of about 3 weeks whilst investigations were being made. The staff of the Chigwell Urban District Council Public Health Department and the health visitors visited the home of every case notified and took specimens of swabs for pathological examination. General medical practitioners were notified of the outbreak and asked to co-operate by notifying any cases brought to their notice.

On the advice of the pathologist at St. Margaret's Hospital, Epping, who gave valuable assistance in this investigation, patients were treated with Streptotriad.

The full enquiry which was held to consider the origin of the outbreak revealed that a contributory factor was that the meat used in the pie had been cooked the day before it was to be eaten and re-heated on the day in question."

Employment of Children.

In accordance with the recommendations of the Children and Young Persons Act 1933 as amended by the Education Act 1944, 3,215 children of school age were medically examined in connection with employment.

C.—ASCERTAINMENT AND TREATMENT OF DEFECTS

School Clinics.

It is not possible to provide details of all the conditions for which treatment has been given to children in the Committee's own Clinics, but the numbers treated for such conditions as skin diseases, other miscellaneous ailments, psychological conditions and speech defects for 1958 are compared in Table 7 below with those for previous years.

Table 7

Conditions for which treatment is given	*No. of children treated*		
	1950	1957	1958
1. Skin diseases, excluding uncleanliness	7,193	5,293	5,421
2. Other miscellaneous minor ailments including enuresis	18,696	8,750	7,658
3. Psychological conditions (at child guidance clinics)	1,116	1,066	1,619
4. Speech defects (at speech therapy clinics)	1,561	2,882	2,705
TOTAL	28,566	17,991	17,403

Diseases of the Eye and Defects of Vision.

The number of children in age groups per hundred inspected at routine periodic medical inspections found to require treatment for defective vision, 1949-1958, is set out in Table 8.

Table 8

Year	*5 to 6 year olds*	*10 to 12 year olds*	*School Leavers*
1949	2.1	5.5	5.6
1950	1.9	4.5	5.3
1951	1.6	5.2	5.5
1952	1.5	5.0	4.8
1953	1.8	5.6	5.5
1954	1.9	5.7	6.0
1955	2.1	5.5	6.4
1956	2.0	6.0	6.0
1957	1.9	5.5	6.3
1958	Pupils born 1953 and 1952	Pupils born 1947 and 1946	Pupils born 1943 and earlier
	2.2	6.8	8.2

Of 26,774 pupils tested, 496 were found to have a defect of colour vision.

Ear, Nose and Throat Defects.

These defects continue to be less commonly found at routine periodic medical inspections (see graph, Appendix E).

Details concerning tonsillectomy in children are given in the tables on pages 66 and 67.

The two pilot surveys on the use of pure-tone audiometers in relation to the early detection of hearing defects made more progress during the year (see Appendix F, page 83).

Skin Conditions.

It will be noticed from the graph Appendix E on page 82 that the frequency with which skin conditions are found at routine periodic inspections to require treatment has remained substantially the same since 1949, and the amount of treatment of skin conditions undertaken in school clinics has remained virtually unchanged since 1955 when 5,294 children were treated.

Other Minor Ailments.

There has again been a reduction in the number of children requiring treatment for other minor ailments.

Enuresis.

During the year, in co-operation with general practitioners, a new weekly clinic for the treatment of enuresis was started in Harlow in the Forest Division, under the supervision of Dr. Ash, school medical officer.

It is too early yet to evaluate various methods of treatment at this particular clinic although it is clear that the electric enuresis alarm is proving to be extremely useful.

In the Ilford Division, where an enuresis clinic has been established for some years, Dr. J. M. Pooley, school medical officer, reports :—

" During the 12 months ended 31st December, 1958 there have been 46 new cases, made up as follows :—

	Under 5		*Over 5*	
	Boys	*Girls*	*Boys*	*Girls*
Recommended by :—				
Parents	—	—	2	—
General Practitioner	1	1	1	—
Infant Welfare Centre Officers	2	1	—	1
School Medical Officers	—	—	22	13
Health Visitors	—	1	—	1
	3	3	25	15

Total = 46 cases

Total attendances (old and new cases)	350
No. of sessions	39

During Dr. Wright's 16 months of office the drugs used have been the same as in previous years with the addition of a supply of long acting Dexten tablets issued for a clinical trial.

The number of cases so far included in the trial has been insufficient to enable any concrete conclusions to be drawn, but further investigation will probably be carried out during the ensuing twelve months and the report will be issued at the end of that time.

The need for a further " Buzzer " for the Ilford Bed Wetters is becoming more pressing ! This fact is being considered and it is hoped that another electrical machine may shortly be added to the one in use at present."

Child Guidance.

With the opening during the year of two more Child Guidance Clinics at Basildon in the South East Division and at Harlow New Town in the Forest Division, the development of the Child Guidance Clinic Services as originally planned in 1950 and subsequently modified, is nearing completion. Details of these Clinics are set out in Appendix J whilst details of the demand made on the clinics are shown in Appendix G. Waiting lists are increasing accordingly, and the school population served by them will be found in Appendix B. The Walthamstow clinic now covers the greatest number, viz. 58,720 children. This figure had increased to 70,619 by 1957 but the opening of the new clinic in Harlow New Town has considerably reduced the numbers attending. The newer clinics in South Essex and Romford are serving the next largest population, whilst the clinics at Chelmsford and Ilford are now only dealing with about half the numbers dealt with eight years ago.

The age groups and sex of the 1,483 children newly referred to Child Guidance Clinics during 1958 are set out below and in Table 10 are given the source of these referrals.

Table 9

Under 5		
Boys	38	
Girls	40	
		78
Primary school children		
Boys	580	
Girls	240	
		820
Secondary school children		
Boys	347	
Girls	238	
		585
Total	1,483	

Table 10

School Medical Officers and Health Visitors	503
General Practitioners	213
Educational Psychologists	210
Head Teachers	63
Children's Officers	141

Table 10 Continued.

Probation Officers	7
Direct referrals	157
Others (e.g. hospitals, etc.)	119
	1,483

The interesting thing to note from these tables is that 5 per cent. of the children were referred before the age of five years and 60 per cent. before the age of 11 years, whilst 65 per cent. of referrals were boys. A little more than one-third of referrals are made by members of the School Health Service. General Medical practitioners account for 14.3 per cent. and approximately 10 per cent. were direct referrals, i.e. the parent called at the clinic and requested an appointment.

The ways in which these 1,483 children, together with the 350 pupils referred from the previous year were dealt with, are detailed in the table on page 89. The salient facts revealed by this table may be summarised as follows :—

397 (21.6%) were still awaiting a first appointment on 31st December, 1958.

Of the remaining 1,436 children who had been seen :—

136 (9.5%) did not require treatment.

178 (12.3%) were being kept under supervision at the clinic.

531 (37.0%) were receiving treatment—
486 at the clinic
45 in residential schools

168 (11.7%) were awaiting treatment—
128 at the clinic
40 by placement in residential schools for maladjusted pupils.

423 (29.5%) were still under investigation or their case had been closed because they had left the district or for some other reason were not attending the clinic.

The distribution of treatment amongst the various members of the staffs of the clinics is also detailed in the table on page 88. A description of the diagnosis and the various forms of treatment undertaken in a child guidance clinic are given in an interesting report from Dr. H. M. S. Davidson, Psychiatrist at the Ilford Child Guidance Clinic. This report is reproduced in Appendix H, page 90.

Nevertheless, it is extremely difficult to assess the quality of such work. An attempt is being made, however, to do just this at the Mid-Essex clinic because the only way of assessing the quality of the work is by judging the results. Dr. Vincenzi, Psychiatrist at the Mid-Essex Clinic, reports about follow-up :—

> "A follow-up of some 247 cases which were seen at the Clinic 1952-55, and the mothers, were interviewed by psychiatric social workers subsequent to our enquiries. The results were somewhat uncertain and time has not allowed the results to be properly assessed. This was only intended to be a pilot venture and if it seems profitable a further investigation might be made later, on more standardised lines. As far as I know no follow-up of child guidance cases has ever been published, and it would be interesting to know the subsequent work and life adjustment made."

Dr. H. N. Davy, Psychiatrist at the Colchester Clinic, reports as to early referrals :—

> "The age of referral needs to be lowered and under fives seen as well as older children. Much educational work is needed to enable the referring agents to spot the first signs of disturbance. If referred at the earliest possible age then matters can be put right for child, parents and family, with the minimum of effort and time."

The proportion of children under five referred during 1956 is in fact higher than for the previous year, which does indicate that the members of the School Health Service and others intimately concerned with the welfare of school children are not unaware of the need for early referral.

Dr. Skynner, Psychiatrist at the clinic in Harlow New Town, also reports on this matter :—

> " My own experience has confirmed that of others, that much can be done in this way to ensure the early recognition of mental disorder at the stage when it is most treatable (most come to us five years too late) and to enable people working in related services to deal with the more straightforward problems themselves in the earliest stages. A new town like Harlow presents an unusual opportunity for community work of this kind and I have already been approached several times by the local Probation Officers and many teachers, as well as some family doctors, who are eager to take part in such mutually helpful discussion of problems."

With regard to new developments in the Child Guidance Service, the opening paragraph of Dr. Davidson's report, reproduced in the Appendix, bears repetition. She writes as follows :—

> " Though we are called a Child Guidance Clinic we are essentially a Family Clinic, our patients are members of a family where personalities react on each other and where problems are closely interrelated."

Dr. Davy also refers to this approach to the work :—

> " Increasing emphasis on preventive work in early childhood so as to reduce the amount of mental ill-health and delinquency in later life, should be our watchword. For this reason I have kept in touch with Miss Spackman, our former Psychiatric Social Worker, and I have visited Shoreditch and discussed their concepts of family case-work and their findings, with the members of the research team of The Shoreditch Project in London. This Project has pioneered social and family case-work for parents and children in Shoreditch. In view of the newer trends in case-work and Child Psychiatry, I contend that " Child Guidance " is a less accurate term than that of a Department for Parents and Children.
>
> I believe that we should not concentrate so exclusively on the child's symptoms—bed-wetting, behaviour problems, sleep disturbances, asthma, for which he is referred to the Clinic for help, because the real cause may lie with some other child or member of the family who is ill or disturbed, or in general sociological changes such as adoptions, smaller families, and both parents going out to work. I would suggest that this broader concept of family and/or social psychiatry, of embracing the needs of the family as a whole, also points the way to the goals of positive health and well-being or prevention of later ill-health. My day-to-day work in Canada, and my studies with " Cornell University " convinced me that this family approach works, though it is time consuming. It is practicable only when child development studies and psychiatry are accepted, when one can work hand-in-hand with all the community agencies, doctors and social workers. (We are, of course, especially fortunate in Colchester in our relation with the School Health Service.) One can then deal with long-term causes instead of a short-sighted attitude to children's symptoms."

The Chief Education Officer has kindly provided the following report on the School Psychological Service, by Miss E. M. Bartlett, Psychologist to the Education Committee :—

> " The Staff of the School Psychological Service has remained almost unchanged for this year. We were pleased to welcome Mrs. Salaman, in April 1958, to give part-time service in the schools of Harlow and the surrounding districts and in the Child Guidance Clinic. Mr. Pickett left for a post under the London County Council in October and it did not prove possible to replace him with a suitably qualified person so that the school psychological work in Ilford and Barking had to be reduced.
>
> The percentage of children seen through the School Psychological Service has remained at about 1 per cent. but in certain areas, particularly in South Essex, where the other professional staff of the Child Guidance Clinic has not been available, the psychologist has had to do more work

in the Clinic and less in the schools. An additional psychologist is urgently needed for the South Essex Division.

The psychologists, in addition to working independently in their respective areas, have continued to function as a team, meeting for consultation and discussion of common problems and combining to carry out certain duties for the Education Committee such as interviewing children in selective secondary schools who have not maintained their original promise, and assessing the educational needs of children moving into the County from other areas, or applying for financial assistance with secondary school education, not having taken an allocation examination at any stage.

The trends in the work noted last year have continued. The proportion of children of good intelligence who are referred for educational problems continues to increase and on the whole more than 50 per cent. of the cases seen in schools for this reason are of average or above average intelligence. One reason for this may be that because of difficulties of staffing a good many schools have had either to give up their special classes for children of poor ability, or have been unable to start these classes so that there have not been the same number of requests for help in the formation of such classes as used to be received in the past. There is also the fact, noted last year, that teachers are increasingly dealing with this problem of educational backwardness through their own skills and experiences, and are only referring to the psychologists cases of backwardness which present special difficulty.

As in previous years, far more children of junior school age than of secondary school age are referred to the psychologist, and at the junior stage far more boys than girls are referred, both for educational backwardness and for problems of behaviour and adjustment. On the other hand, at the secondary school stage, the percentage of girls referred is much greater. It would be of advantage to the children if the potentially difficult adolescent girl could be detected earlier and given help at the junior stage. By adolescence it is very much more difficult to readjust these girls. This problem is similar to that found in the sphere of residential placement.

In addition to dealing with individual cases of educational backwardness, the psychologists have continued to organise work in the schools for groups of children of good ability who are falling behind. It is easier to press forward with this side of the work as there are a number of retired or married women willing to do part-time work but not available for a full-time post in schools. Most of these groups meet on a part-time basis for the children as well as for their teachers but the full-time special classes in Ilford have continued as before and serve a useful purpose for mildly maladjusted children who do not need to go away from home.

The rural areas of the County are being helped through full-time specially trained peripatetic teachers and there are now two of these working in the Mid-Essex Division and similar work is being done in other areas. The teachers doing these types of remedial work meet from time to time with the psychologist concerned to discuss common problems and to see books suitable for their work.

The other aspects of the psychologists' work continues much as before. Where time allows, the psychologist acts as a ' go between ' for the Child Guidance Clinic and the schools, following up the progress of children attending the Clinic and trying to keep the teachers informed about their progress. The psychologists have also continued to give Courses of lectures to Parent Teacher Associations, Young Wives Clubs, Women's Institutes and other bodies. Three of the psychologists have again been responsible for the talks on Child Development at the residential Course for Housemothers and Housefathers organised by the Home Office at Wansfell Adult Centre."

Speech Therapy.

The number of children given speech therapy in the Committee's clinics was a little lower during 1958 than for the previous year but slightly more of the children were of pre-school age. The report of Mrs. M. Walker, the Senior Speech Therapist in Ilford, refers to these younger children. The effect of speech therapy is also shown in the details concerning discharges at the end of her report and similar results might equally be given by other clinics :—

" This year has seen more pre-school children referred for speech therapy than ever before. One obvious result is the possibility of preventing a more severe form of speech disorder developing, as has happened so often in the past when parents waited for spontaneous improvements or confused the child with too frequent correction. It has also given the opportunity for greater experiment in group treatments for the under fives, and in most cases this has proved much more satisfactory than the somewhat unnatural one-child : one-adult therapist situation. Also it gives many of these children the only opportunity during their week to play with other children of their own age and interests. Each child of course has a short individual session during the group period with the therapist.

At the other end of the age scale, several boys have been recommended for speech therapy. These boys apparently had been known to stammer for 2-4 years and had not been referred for speech therapy until they had become severe psychogenic stammerers ; by then they were generally in, or approaching, adolescence. This is recognised as being the most notoriously difficult period in which to attempt treatment.

The importance of not waiting for children to grow out of their speech difficulties is stressed once again. Consultation between the **parents** and the speech therapist at an early stage could preclude the need for some of these children to receive treatment in the actual clinics.

The defects treated were as follows :—

Stammer	53
Dyslalia	130
Retarded speech and language	13
Hearing Losses	7
Cleft Palate	6
Dysarthria	4
Neurological	1
Treatment not needed	4
Others	9

96 children of school age were discharged from the Clinics during the year. In 63 cases the speech was normal. Of the remaining 33 cases, 13 left the district, 1 improved, 7 ceased to attend, 6 left school, 2 were referred elsewhere, 4 did not require treatment."

Paediatric Clinic

Dr. Elchon Hinden, Paediatrician to this Clinic at Walthamstow, reports as follows :—

"The work of the school consultative clinic has not changed significantly over the past year. The maintained good health of the schoolchild has shown itself in a low level of referrals. As in the past, most of the children are picked out by the school health medical officers at their routine inspections.

The increasing size of school children is a matter of general knowledge ; it is perhaps not so well known that biological maturity now occurs much earlier than formerly. Wherever detailed statistics have been kept, the figures show that the onset of puberty is advancing by about 1 year, every 30 years of time. It follows that the weight and height of children today are not really comparable with those of their fellows of the same chronological age, one or two generations ago, for now they are, compared with them, at an advanced "pubertal age"—and that is what matters. Certainly most of the schoolboys and schoolgirls who are referred to me after their final inspection, when they are about to leave school, are clearly young men and women, and not children at all.

Plainly, this earlier ripening of children is a matter of great importance both to the educationalist and sociologist. It is a curious paradox that a century ago children left school at 11 or 12, when they were still children, and were expected to work and behave as adults ; whereas now they are kept at their lessons till 15 at least, and treated as children, while in fact they have been adult for a couple of years ! It is ironical that the school-leaving age should be rising just as steadily as the age of adolescence is falling. The difference between the way society treats these young people and the obvious maturity of their bodies, is bound to set up stresses in their personalities, and may well be an important factor in the most paediatric disease of our time—juvenile delinquency.

The following cases were seen :—

	Over 5 years	Under 5 years
New cases	45	18
Total attendances	113	33
Physical Defects :		
Number of cases	88	33
Referred to Hospital	13	5
Discharge	18	7
Psychological Disorders :		
Enuresis	7	—
Other	5	—
Referred to Hospital	2	—
Discharged	2	—

D. ASCERTAINMENT AND SPECIAL EDUCATIONAL TREATMENT OF HANDICAPPED PUPILS

A summary of the number of handicapped pupils in the Authority's area will be found in Appendix B on page 70. It should be noted that of the total school population, 1.14 per cent. have been formally ascertained as handicapped pupils.

Blind and Partially Sighted Pupils

There were 58 children ascertained as blind on 31st January 1959, which is 7 less than the previous year. The incidence of this handicap amongst Essex school children is now 0.21 per thousand pupils and it is to be hoped that the peak incidence of such handicapped children reached in 1953 has now been passed (see Table 11 below).

Table 11

Incidence of Blind Pupils per 1,000 school population

1949	1950	1951	1952	1953	1954	1955	1956	1957	1958
.18	.21	.22	.23	.25	.23	.22	.24	.23	.21

Only 8 blind children were awaiting special placement at the end of the year ; four of these children were under the age of 5.

There were 73 pupils ascertained as partially sighted and requiring special educational treatment, although another 22 children with some degree of handicap were attending ordinary schools.

Almost half of these partially sighted pupils were attending the day special school in Walthamstow.

Mr. Williams, Headmaster of this School, has submitted the following report :—

" The table below shows the principal defects in the children at the school at the end of the year :—

	Boys	*Girls*		*Boys*	*Girls*
Albinism	3	5	Ectopia Lentis	—	1
Anisometropia	1	—	Microphthalmos	—	1
Cataract	7	2	Myopia	3	6
Cerebral defect	1	—	Nystagmus	2	—
Chorodoitis	—	1	Optic Atrophy	3	1
Coloboma	1	1	Retinal defects	4	1
Corneal ulceration	1	—	Retrolental fibroplasia	—	1

As in previous years the ophthalmic supervision of the school has been well maintained. Dr. I. Gregory, M.B., D.O.M.S., made visits in May and October for the purpose of examination and has given much helpful advice. The medical staff of the eye clinic have made regular ophthalmic examinations and Mrs. Suckling has given ready and efficient service in the supply and repair of spectacles. The willing help of all at the eye clinic has been much appreciated.

In June there was a full medical inspection of all children in the school, and Mr. Taylor from the school dental clinic visited the school for dental inspection.

The hearing of all new admissions and certain selected cases was tested on the pure-tone audiometer by Mrs. Leach of the School Nursing Service.

During the Whitsuntide holiday, a party of twelve children under the care of Mr. Crosbie spent a week at the Isle of Wight in company with the Woodside School Camp party. This proved to be a most instructive and worthwhile venture.

At the end of the summer term, Miss Ramage, deputy Head Teacher, retired from teaching, having given many years of valuable service to the school. She was the sole remaining link between the former Walthamstow Blind School and the present partially sighted school. The vacancy thus caused was filled by the appointment of Miss R. Baggs to the staff.

The average number on roll during the year was 43, with an average attendance of 34.2 Seven children were admitted, and three children were taken off roll, one boy being transferred to a school for the blind, one boy leaving to be trained for industry as a blind person, and one girl suitably placed in light factory work.

Visitors during the year included medical officers from Jugoslavia, the Philipines, Hong Kong, post-graduate medical students, student health visitors, district nurses and training college students."

Deaf and Partially Deaf Pupils.

There were five pupils newly ascertained as deaf during the year, while the decline in the number of children handicapped by total deafness continues to diminish. The incidence of partially deaf children continues to rise.

Children attending the William Morris School for the Deaf, Walthamstow, come from a wide catchment area extending over a radius of 20 miles and some of the youngest children come from the most distant places, e.g. Harlow, Hutton and Barking, in order to obtain the special educational treatment they require. Mr. K. S. Pegg, Headmaster of The William Morris School, the Authority's day school for the deaf, reports as follows :—

" The school reopened in January, 1958, with 47 on roll. During the year eight children were admitted and three left. Two of the three children were transferred to other schools, one to a school for the deaf in Middlesex and the other to a secondary modern school for girls. The third left to take up employment as a carpenter. The roll at the end of the year was as follows :—

Class	*Grade*	*Age Range*	*No. on Roll*		Congenital				Acquired		*Actiology Unknown*
			M.	*F.*	*Hereditary*	*Kernioterus*	*Prematurity*	*Unspecified*	*Post Meningitis*	*Other*	
1	Reception	3- 7	5	5	1	2	1	3	—	—	3
2	Deaf	8-11	3	4	1	1	—	3	1	—	1
3	P.D.	7-12	5	6	—	—	—	2	2	2	5
4	Deaf	9-11	3	2	1	—	—	2	2	—	—
5	Deaf	13-15	5	2	—	—	—	3	2	1	1
6	P.D.	12-16	6	6	1	—	—	4	5	2	—
Totals			27	25	4	3	1	17	12	5	10

Catchment Area—

Barking	2	Ilford	7
Barkingside	1	Leyton	5
Chadwell Heath	3	Loughton	4
Chigwell	1	Nazeing	1
Chingford	1	Purfleet	1
Dagenham	1	Romford	6
Edmonton	1	Walthamstow	5
Harlow	3	Wanstead	1
Hornchurch	1	Woodford Bridge	4
Hutton	1	Woodford Green	2
		Cheshunt (Herts)	1

There is already installed one group aid suitable for the senior class but this is a fixed aid necessitating the use of head-phones plugged in to the child's desk and is unsuitable for young children.

A number of cases have tried the "Telesonic Induction Loop System." This system is designed to provide high quality sound reproduction while eliminating those restrictions on movement and classroom layout which the earlier type of "fixed" installation demanded. It allows children to move about in the class and even in the playground and still clearly hear the teacher's voice. The teacher also can move freely, within the limits of a long lead (suspended from the ceiling) and can move among the class and demonstrate on the blackboard, etc.

Even with the best adjustment possible, an ordinary hearing aid produces great distortion because of interference by background noises. These noises cannot be eliminated in a classroom of small children. The Loop Induction system also overcomes this difficulty by providing direct communication between the teacher's microphone and the child's ear-piece. The child's hearing aid incorporates a three-position switch :—

(1) Listening Loop only ;

(2) Normal microphone plus listening loop ;

(3) Normal microphone only.

On position (1) it is possible to hear the teacher's voice clearly despite noisy surroundings. This system has already been adopted and has given excellent results in several schools for the deaf and the new Government transistor aids will all incorporate the Loop Receiver. It is anticipated that these aids will be issued to children attending the school fairly early in 1959 and it has been recommended that three commercial transmitters be obtained at a cost of approximately £60/£70 each so that three classes can be equipped with the Loop system.

During the year, formal approval was received from the Ministry of Education in regard to the provision of commercial transistor aids. Pending the provision of Medresco transistor hearing aids, commercial aids were obtained on the recommendation of Mr. Cammock, the Ear, Nose and Throat Consultant appointed to the School.

A number of hearing aids were supplied to children attending normal schools, and in some cases children attended once or twice a week for auditory training or practice in lip-reading. It is hoped that, in the near future, it will be possible to help more children in this way.

During the year we have taken delivery of a further Speech Training Unit, which is of great use in the School, and through the generosity of the Parent/Teacher Organisation magnetic recording tapes were made available and a speech record was made of every child attending the school.

Mr. Taylor, of the School Dental Service, attended the School in September and held a full dental inspection. A total of 159 minor treatments have been given by the nursing staff An average attendance of 86 per cent. was recorded.

Miss Smith, Educational Psychologist, made a number of visits to the school for the purpose of examination."

Of the 102 deaf children in Essex, about half are in day school, the remainder in residential schools for the deaf and only two were awaiting admission. In addition to these children, 147 children in the County have some degree of hearing loss which is overcome by the use of hearing aid to such an extent that they are able to make perfectly satisfactory progress in an ordinary school. (When a survey was carried out in 1956 of the number of such children in ordinary schools, the figure returned was 82).

Delicate Pupils

At the end of the year, there were 396 delicate pupils in the County ; this represents a considerable reduction on the previous year. Of these pupils, 205 children are placed in day schools in Essex ; 175 are in residential schools or boarding homes, 6 are receiving home tuition and only 10 await placement. As anticipated, the opening early in the year of the Committee's residential school for delicate children at Clacton has provided accommodation for the majority of those awaiting boarding placement.

The school has accommodation for nearly 100 children of primary school age and normally children spend a period of not less than two terms in the first instance at the school. Dr. Ann Clark, School Medical Officer, attending the school, has submitted the following figures concerning admissions and discharges during the first year :—

Admitted

80 — 45 boys
35 girls
(ages 6—13 years)

Conditions on Admission

Asthma	35	60%
Bronchitis and other respiratory conditions	13	
General debility	12	
Nervous debility	1	
Delicate	7	
Sub-nutrition	6	
Heart condition	1	
Mesenteric adenitis	1	
Cerebral palsy	1	
Maladjusted	1	
Behaviour problem	1	
E.S.N.	1	
	80	

Discharged

Reasons for discharge

Medically fit	3	
Transferred	2	(1—Day Special School for Delicate Pupils). (1—Residential Special School for E.S.N. Pupils).
Improved housing conditions	2	
Admitted to hospital	1	
Found unsuitable	1	(Maladjusted)
Withdrawn by Parent	6	(did not return after Holidays at home)
	15	

Physically Handicapped Pupils

There were rather more children ascertained as physically handicapped during 1958 than during the previous year, bringing the total of these children in Essex up to 506, of whom 116 were in hospital special schools. Of these children, 71 were registered for the first time in 1958. The Committee's day schools are accommodating 201 physically handicapped children, 90 are in residential schools or boarding homes and 48 are receiving home tuition. There are still 51 children awaiting placement, 44 in residential schools, an unusually high figure compared with previous years.

The tendency for Open Air Schools to take physically handicapped children and schools for the physically handicapped to take delicate children is one that has been evident for a number of years. Today, for instance, the Grays Open Air School has 20 physically handicapped children among its 94 pupils, the Barking Open Air School has 26 physically handicapped among its 85, the Walthamstow School for the physically handicapped has 32 delicate children on its register of 89 pupils whilst, of the 24 children admitted in 1958 to the Benton Road Open Air School in Ilford, 14 were physically handicapped.

The type of condition for which children are admitted to these schools is shown in the report of Dr. P. J. Roden, School Medical Officer attending Grays Open Air School :—

"The conditions for which the children have been admitted are given below :—

Asthma	24	Bronchitis	3
General debility	14	Bronchiectasis	8
Primary Pulmonary Tuberculosis	4	Congenital heart disease	3
Rheumatic carditis	3	Fibrocystic disease of pancreas	3
Portal cirrhosis	2	Hemiplegia	2
Effects of Ant. Poliomyelitis	2	Lobectomy	2
C.S.O.M.	2	Congenital deformities	2
Congenital dislocation of lens	1	Erythema Bullosa	1
Cutis Hyperelastica	1	Oesophegeal hernia	1
Lymphangioma of face	1	Anxiety State	1

Throughout the year remedial treatments have been continued. The therapeutic measures employed are rest, graded to suit the individual requirement, breathing exercises, postural exercises, postural drainage, and special exercises where appropriate.

A large percentage of pupils are under specialist supervision either locally or in various London Hospitals, and many attend regularly for out-patient treatment in physiotherapy ; periodic visits are made by a number of children to the chest clinic. Four children had periods of convalescence.

On the whole the children are mentally and emotionally normal, but cases of minor adjustment and behaviour problems are naturally more numerous than in a cross section of pupils aged from 5-16 attending ordinary schools.

Average school attendance is poor, due largely to exacerbations of the condition for which the pupil was admitted ; to surveillance visits to family doctors, specialists and hospital out-patient departments.

The average increase in heights was : boys 2.1 in., girls 3.3 in. The average increase in weight was : boys 6¾ lbs., girls 10½ lbs.

The average age of the children rose, so that at the end of the year there were 36 children (17 boys, 19 girls) over eleven years and 44 (27 boys, 17 girls) under eleven.

The average length of stay, of those leaving, was 2 years 6 months with a range from 2 months to 7 years 6 months. The number discharged was 22, as follows :—

Admitted to Residential Open Air School	1
Removed from area	3
Of school leaving age and fit to leave	5
Found fit to resume attendance at ordinary school	13 "

Many of these children in day schools have dual handicaps, a point to which Mr. G. M. Williams of the Wingfield House School for the Physically Handicapped in Walthamstow refers :—

> " The number of children with more than one handicap shows no sign of diminishing. There were 21 children with poor mentality allied to other difficulties ; 3 children were found to have hearing disabilities necessitating the provision of hearing aids, 13 were having regular speech therapy and 4 children have three major difficulties. There were 8 non-ambulant children on the roll."

The wide variety of conditions affecting children in these schools is also shown in the details provided by Dr. V. Spiller, the School Medical Officer, concerning pupils at the Faircross Open Air School at Barking (see Table 12 below). Treatments are also detailed in this table and the extent to which the children have more than one handicap, particularly the educationally sub-normal children is clearly demonstrated also :—

Table 12.

Handicap and Treatment of Pupils at Faircross Open Air School, Barking.

208 pupils:	*26 Physically Handicapped*	*123 Educationally Sub-normal*	*59 Delicate*
Children from :			
Barking	16	43	11
Dagenham	1	21	20
East Ham	4	0	14
Ilford	0	45	0
Romford	5	14	14
Handicap :			
Backward	9	123	11
Congenital Heart	1	3	—
Enuresis	3	11	1
Epilepsy	4	12	1
Eye defect	3	19	—
Hearing defect	1	16	2
Lung condition (mainly asthma and bronchiectasis).	—	6	42
Paralysis due to :			
poliomyelitis	6	—	—
cerebral palsy	5	3	—
accidents	2	—	—
tuberculous meningitis	1	—	—
Others :	1 Christmas disease 2 congenital deformities and disabilities 1 fragilitas ossium 1 hydrocephalus 1 Perthe's disease 1 rheumatoid arthritis	2 cretins 1 diabetes 1 dwarf 1 Sturge-Weber syndrome	1 Anaphylactoid purpura 2 dextrocardia 2 eczemas 1 Ehler Donlos syndrome 1 fibro-cystic disease of pancreas 1 migraine 1 nephritis 1 tuberculous knee 1 ulcerative colitis
Treatment :			
Child Guidance	2	9	5
Hearing Aid	1	2	1
Physiotherapy :			
(Breathing ex.	1	—	29
(Post. drainage	—	—	9
(Remedial exerc.	15	3	2
(U.V.R.	—	1	1
(Calipers	5	—	—

Treatment—Cont.

Speech Therapy	7	24	8
Treatment at home	6	8	20
Attending hospital	14	28	21

Pupils with Cerebral Palsy.

Dr. D. M. B. Gross, School Medical Officer, has submitted the following report on the Ilford Cerebral Palsy Unit :—

" The Unit has now been open since May 1955 and at the end of 1958 there were 22 children on roll, 12 males and 10 females. One child from the Ilford Division appears on the waiting list and will be admitted on reaching five years of age.

During the year two children were examined with a view to admission ; one was accepted and came from the Ilford area ; the other child from the Mid-Essex Division was found unsuitable owing to the fact that she was not a true cerebral palsy.

5 children were discharged for the following reasons :—

1 Remove to Basildon
2 Transferred to Residential Special School
2 Reported ineducable under Section 57(3) Education Act 1944.

Admissions (all boys) in 1958 were as follows :—

1 Cerebral Palsy
2 Athetosis
1 Generalised spasticity
1 Spasticity of lower limbs.

Moreover 4 children under 5 years (3 from Ilford and 1 from the Forest Division) were seen and examined. These would have been suitable for admission to a special nursery school had such been available. The need for such a nursery school is thus again emphasised if full use is to be made of the Unit, all authorities being agreed that the earlier training and treatment can be started, the better,

The work of filming the children continued throughout the year and, with the cine projector, is proving most useful to therapists and medical staff alike ".

The need to increase the facilities for handicapped children of nursery school age is also referred to by Dr. G. Poole, School Medical Officer, Walthamstow Division, attending the William Morris School for Physically Handicapped Children where persistent requests for admission of handicapped children below the age of 5 years have been made :—

> "It is well recognised that whatever the handicap, the earlier the age at which the child is brought under effective treatment and training, the better is the final result. This is particularly true of deaf children, who are being admitted at the age of 3 years or even younger, but there is a good case for the admission of other categories of physically handicapped children below the age of 5 years as soon as additional staff and premises can be provided.
>
> Since the aim of the special school is to fit its pupils to return to normal schools wherever possible, it is evident that an extra year at the beginning, instead of at the end of school life, would be of greater value in many cases, besides providing very real relief to the parents of severely handicapped children."

The after care of physically handicapped children has received special attention during the year. Every effort is now made to examine children attending residential schools some 12 months before they are due to leave their school in order to consider whether they will benefit by registration as a handicapped person under arrangements made by the County Welfare Officer.

The difficulty of finding suitable employment for these children continually exercises the ingenuity of those concerned with their welfare. This is another point referred to by Dr. G. Poole in his report on the Walthamstow School. He describes how they are meeting this problem there :—

> "The current reduction in the demand for juvenile labour in the district is being reflected in the increasing difficulty in obtaining suitable employment for pupils leaving the special schools, particularly those who remain severely handicapped.
>
> A case committee of officers was set up with the co-operation of the Borough Education Officer to consider individual cases and co-ordinate effort. Two meetings were held (a third having to be postponed because of illness) and representatives of the Principal School Medical Officer, the Borough Education Officer, the Borough School Medical Officer and the Youth Employment Officer discussed general provisions and individual cases brought up by the Head Teachers of the special schools and by the Educational Psychologist.
>
> The greatest problem was found to be the placement of those children who were so heavily handicapped, often with more than one disability, as not to be employable in any ordinary sense and unlikely to be so by any vocational training.
>
> Arrangements have since been made for all handicapped pupils to be notified to the County Welfare Officer before they leave school so that the size of the problem can be assessed and suitable provisions made by the County Welfare Authorities.

It is hoped that arrangements will be made in the near future for the establishment locally of a workshop where these young people can be given some work, even if only of a recreational nature, and can enjoy the stimulus of companionship, which is denied them so long as they remain homebound."

In the Dagenham Division the arrangements are slightly different. Dr. H. E. Mair, the School Medical Officer attending Bentry Road School, Dagenham reports :—

" All school leavers have an interview with the Youth Employment Officer and Headmaster, and as in the previous year, the School Medical Officer attended each time to discuss their future, and the suitability of employment. A representative of the County Welfare Department now attends these interviews to take over any unemployable children, and to register those with a serious handicap. This addition to the school leaving interview is of importance as a link between the three services, Education, Health and Welfare, and ensures close co-operation between the departments.

All Dagenham physically handicapped children who had left Bentry School since 1955 were seen by the School Medical Officer responsible for Bentry School, either in the Civic Centre or in their homes, and in the case of those not able to work, or bedridden, contact made with the Youth Employment Officer, Welfare Departments and Association for Physically Handicapped, and in a few cases referral to hospital for further treatment was arranged."

In the Ilford Division, the Youth Employment Officer meets the School Medical Officers to discuss the cases and, in addition, there is a constant liaison between the staff of the School Health Service and the Youth Employment Service. In the South Essex Division, when a child is due to leave Grays Open Air School, arrangements are made for a discussion to take place between a member of the staff of the Youth Employment Bureau, the parents, the Headmistress and the Medical Officer attached to the school to ensure that the child obtains suitable employment, whilst in the Barking Division a brief medical report is completed and forwarded for use at the school leaving conference between parents, Head Teacher and the Youth Employment Officer.

Educationally Sub-Normal Pupils.

The number of educationally sub-normal children requiring special educational treatment at the end of 1958 was 1,524. Of this number, 308 had been newly assessed as handicapped pupils during the year. The incidences in the various Divisions are detailed in Appendix I on page 94.

Dr. A. T. W. Powell, Divisional School Medical Officer at Walthamstow, reports as to waiting lists :—

> " The additional class at the Margaret Brearley School provided in 1957 has helped considerably in reducing the waiting list for the admission of educationally sub-normal children, but the present total of 120 cases is still insufficient to cover the need. To some extent this has been met by the establishment of two small remedial classes for dull and backward children ; one at Woodside Junior School for children aged 9-10 years and one at Mission Grove for the 7-8 years age group. However, the waiting list is again building up and there appears to be a need for the establishment of two or more remedial classes for children of secondary school age.
>
> One is always reluctant to recommend the transfer of any child to a special school as this inevitably means some deprivation of its opportunities for normal development and increases the risk of perpetuating a ' handicapped ' attitude into adult life. This consideration applies especially to the transfer of children of secondary school age to the E.S.N. school.
>
> Nevertheless, although in any group someone must always be at the bottom, there are some children in secondary modern schools so far behind their age group in ability and attainment that they are unable to progress unless given a disproportionate amount of the teacher's time. The transfer of one such ' lame duck ' to a remedial class where more individual attention can be given will not only raise the child's own attainment but may positively benefit the class he has left by allowing them to proceed at a faster rate."

During the night of March 30th, fire broke out in the roof of the Margaret Brearley School for the educationally sub-normal children in Walthamstow. Three classrooms and part of the hall were severely damaged and the pupils had to be accommodated temporarily in another school in the Borough. They were able to return to their own premises at the beginning of September.

The new day school opened at Corbets Tey two years ago has settled down and Dr. W. T. G. Boul, Divisional School Medical Officer, South Essex, reports on the school :—

> " This school was opened two years ago and has maintained its full roll of 140 this year.
>
> Two children were deemed no longer in need of special education and were found employment which they have maintained so far. Three more children were thought to have progressed sufficiently for them to have a trial period in an ordinary school. It was thought wise to give them two terms trial in the ordinary school with a prior right to re-enter Corbets Tey should they not be found to maintain their position.

The school is still admitting younger children under observation although it is suffering from the bulge.

Routine and special medical inspections have been carried out by the three approved Medical Officers who visit the school every month, but the visits have been restricted owing to illness. In addition repeat intelligence tests have been done on children who have not been tested for two years. Social and academic progress are reviewed once in two years, or as occasion demands.

There is a long waiting list of children to be admitted, in view of which it will now be two years or more before a child can be admitted.

Parents have co-operated well in attending the medical inspections.

During the course of the year an additional Speech Therapist was appointed to the Division as a result of which it was possible to allocate further sessions to the School."

In September 1958, Moat House Day Special School for educationally sub-normal children was opened in Basildon and made a marked impression on the number of children awaiting special placement.

This new school is designed to accommodate 120 educationally sub-normal children in the 6-16 years age range. There are six classrooms divided by the Hall/Dining-room into two sections of three classrooms each. The Junior Department has a self-contained reception room and two classrooms, while the Senior has one classroom and two dual-purpose rooms, one for woodwork and one for housecraft. Attached to the latter room is a three-room " flat " consisting of kitchen, dining-room and bathroom. There is also a medical inspection room.

The full staff will be a Head and seven teachers but as the school, as a matter of policy, opened with only 50 and increased to 78 in the first term, i.e., by Christmas 1958 and was not expected to reach its maximum capacity for another year or so, the Head has only five teachers, plus a School Assistant and a School Attendant.

The School Medical Officer for this school reports very favourably on the general condition of the children. The attendance of parents at school medical inspections has been remarkably good considering the distance which many have had to travel to get to the school. A common comment from these parents has been that at last their children are happy at school and beginning to learn. The Health Visitor/School Nurse from the nearby Honeypot Lane Health Services Clinic visits weekly at least and more often if required. Unfortunately, lack of staff has not permitted the attendance of a speech therapist at the school so far.

All the children in the school are in process of being tested by the educational psychologist in the course of routine visits.

One need for which the school cannot provide in the existing building is for the five-year-olds who are likely to be or have been found educationally sub-normal and who are proving too much for the infants' schools to cope with because of their difficulties of behaviour. The suggestion has been mooted that some accommodation at this school might be provided for this small but difficult group.

Dr. M. Watkins, Divisional School Medical Officer, Leyton, reports on the Harrow Green and Leyton Green Special Schools for educationally sub-normal children in Leyton :—

> " In previous years the returns of routine and special inspections at Harrow Green and Leyton Green Schools have been incorporated in the returns for all Leyton Schools, but now that these are classified by year of birth it is proposed to report them separately in future.
>
> 1958 was an unusual year in that a large number of children were reported to be unable to benefit from education under section 57(3) of the Education Act. Nine of the 12 children were in the Junior School and had been admitted on trial, the majority to the Nursery class. Three of them were mongolian defectives, and the I.Q.'s were around the 50 mark. None had been less than one year in school, others had two to three years' trial there. They were no longer fitting into the educational setting of the educationally sub-normal school, and a child of eight to nine years cannot be moved out of the Nursery class into a more senior class if it has not developed intellectually enough to grasp the simplest rudiments of reading and number. Also several of these children become difficult in behaviour through frustration at being unable to do the things the other children do and inability to cope with an environment beyond their comprehension.
>
> The mongolian defective child is educationally a different problem from other retarded children. It would seem that an I.Q. of 60 or over is required before he or she shows any aptitude for learning reading or number. At one time no mongolian child under I.Q. 60 was accepted to the educationally sub-normal school but of recent years children with I.Q.'s of 50 and over have been admitted to the nursery class and it is hoped that after some years a pattern of experience will emerge which will be of use in assessing their potentialities. So far, however, not much success can be recorded with these children.
>
> One observation, however, can be recorded now. It is that mongolian defective children take longer to settle into the school if admitted between 5 and 6 years than other defective children and last year two girls with I.Q. respectively 60 and 70 were suspended from school for 9 to 12 months because they just could not bear the long day away from home. The parents themselves were aware of this and gladly agreed to the suspension. Both children are back at school and doing a little better now.

In the 1955 report on these Special Schools we were hopeful that the nursery class would prove very useful in helping children on the borderline of educability to a better standard, but after some years experience we are not so sure that admission at 5 years is quite so sound a principle. The child with I.Q. around 50 has a mental age of two and a half to three years and is really not emotionally mature enough to be in a class of twenty children with one teacher only to look after them and teach them. ' Look after ' is an under-statement : they require practical help for all personal tasks and it is too much for even the best teacher to cope with. Requests for a nursery trained helper, not necessarily a teacher, have already been made but so far without success. Now that so many day nurseries have been closed and nursery trained wardens are available, a fresh attempt should be made for Mrs. Scott, in charge of this difficult class, to have assistance. If it is not possible to do so, the work of the class is bound to be adversely affected.

There were four children able to leave school without being notified for supervision. The Headmaster has followed up these cases and all are suitably employed and doing well. Of the seven requiring supervision, two have not been successful in finding work suitable to their abilities and are in difficulties, but recent information suggests one may be suitably placed by now.

Six pupils were de-ascertained before the age of 16 years. Their educational attainments and social maturity were such that they were quite fit to be recommended as no longer in need of special education and were suitably placed in work by the Juvenile Employment Officer with whom the School and medical staff co-operate in assessing the work the children should attempt.

The number of children in the Senior School who show emotional instability is very high. Many of these children are of inadequate personality and are erratic and difficult at home as well as in school. They feel their failure, even when their parents understand their problems. Also some children with I.Q.'s in the 70 to 80 range are school failures because of an emotional disturbance allied to mental dullness. If they did not have this added difficulty they could probably have " got by " in the " C stream " of an ordinary school. It is very encouraging, however, that very few children wish to return to the ordinary school and how gratified the majority of the parents are with the progress their children make in Harrow Green. There are of course a few children within the higher I.Q. range of around 70 who fail to learn to read beyond the infant standard, but they develop an assurance in other ways that helps them to cope reasonably well with the industrial world.

The number of emotionally disturbed children in the Junior School returns this year shows up rather higher than is usually the case there and especially so among the boys. It so happened that 6 of the 9 ineducable children were boys and were very difficult children in behaviour, and the three boys who went to Residential Schools during the year were emotionally unstable because of poor social backgrounds, their difficult home conditions being the reason why they were recommended residential schooling.

One boy with very poor physique and with recurrent chest trouble and eye infections was recommended for home tuition. He never attended school for more than a few days at a time, his I.Q. was low and it was impossible to decide whether he was capable of education or not as he was never at school long enough for any work to be done. One boy returned to ordinary school. He was found to have an I.Q. of 80 and he made rapid progress in a short time. As he was a boy who suffered severely from travel sickness his ability to return to an ordinary school was fortunate and relieved the boy and the coach attendant of much unpleasantness.

Three children at Harrow Green School have hearing aids. Two of them are not severely deaf and only one child wears her aid regularly. One girl cannot be made to wear her aid and from pure tone tests carried out it is very doubtful if she really needs it, lack of concentration being a considerable factor in her hearing difficulty. The other case has managed very well educationally even though he refuses to wear his aid : in a small classroom with twenty children only in the class and with the individual attention given he hears all that is said to him in class. It is unfortunate that his parents have not been co-operative in making him bring his aid to school, because his hearing difficulty affects him in the more general activities in the playground and hall, but he still refuses to bring his aid with any regularity, and parental indifference at times is very hard to overcome.

The schools are visited frequently each term by the school nurse for general surveys but she also visits at any time if the school staff request a visit. Both schools have easy access to clinics. Leyton Green School is adjacent to the Leyton Green Health Centre, and the Senior School is only five minutes' walking distance from Park House Health Centre and is within easy reach of it.

The School Medical Officer visits each school for one session each week. Besides regular inspections at these sessions any pupil is seen at the request of the headmaster or teaching staff or parent. Parents can request a review of their child's progress or an examination at any time and it is never refused. 1958 was a rather unfortunate year for seeing parents of the younger children at Leyton Green School. The 'bus strike prevented the attendance of many parents during the summer term, and the frequent fogs in November and December prevented the completion of periodic inspections at Leyton Green as neither children nor parents could attend.

However, as the staff are very closely in touch with the children, those who appeared to be in need of medical advice were seen sometime during the year and no adverse results were reported.

Mr. James, the Headmaster, has commented on the general improvement in the health and physique of the children over the past few years. At present no pupil suffers from a serious heart complaint and the number of epileptics is down to 3 only, one of these being really seriously affected. Her medication is so heavy it is affecting her educational progress. At times it would seem worth while leaving off the drugs as her fits are not controlled. Anyway it might be an experiment worth trying, but this of course could only be attempted if her medical advisers agree.

Number on Roll 1958	Leyton Green School —	76	195
	Harrow Green School —	119	

	From Leyton Division	*From Forest Division*
Number on Roll—1958	85	110
Number admitted 1958	15	19
Number left	17	22
Reasons for Leaving :—		
1. Attained age of 16		
(a) Notified under section 57(5)	2	5
(b) Not notified	6	4
2. Notified as Ineducable under Section 57(3)	5	7
3. Removal to other areas	1	1
4. To Residential School	3	2
5. To Epileptic Colony	1	—
6. Returned to Normal School	—	1
7. Reported for Home Tuition	—	1 "

Altogether, 890 sub-normal children are receiving special education in day schools in the County.

There are 359 children in residential schools and the waiting list for similar placements has fallen appreciably during the year from 167 to 77. This is largely due to the opening of a new boarding school for educationally sub-normal boys of senior school age at Chigwell.

During 1958, 109 children were ascertained as ineducable under Section 57(3) of the Education Act, 1944. 122 school leavers were recommended for supervision following examination under Section 57(5).

Maladjusted Pupils

The incidence of maladjusted pupils amongst the school population is 1.06 per thousand.

Of the 250 children already receiving special educational treatment, the vast majority, 228, are in boarding schools. There were 50 children awaiting similar placement at the end of this year, four more than a year ago.

Epileptic Pupils

Epileptic Pupils are those who, by reason of epilepsy cannot be educated under the normal regime of ordinary schools without detriment to themselves or other pupils. The actual number of children varies little from year to year. In 1958 there were 37 such children either receiving special educational treatment or awaiting placement, as follows :

Day Schools	5
Residential Schools	28
Hospital Special School	6
Awaiting Placement	8
	37

REPORT OF THE PRINCIPAL SCHOOL DENTAL OFFICER FOR THE YEAR 1958

Staff.

On December 31st the number of dental officers in post was 20 whole-time and 51 part-time and sessional officers giving an equivalent whole-time total of 36.2. The establishment is 87. The whole-time equivalent for 1955 was 42.7, for 1956 44.3 and for last year 39.4 and since 1955 the school population in the Administrative County has increased by some 20,000, which is enough load for six more full-time dental officers. The evening sessions undertaken add the equivalent of 1.6 full-time officers and this figure is not included in the total mentioned above. The principle of part-time work is fully established and the part-time staff now accounts for nearly half the total sessions worked. So far as one can foresee, this state will continue and the help received from part-time staff is most valuable. In fact without this the scheme could immediately degenerate into an emergency extraction service. About 10 per cent. of the available time is given by arrangement to the Maternity and Child Welfare Services of the Authority.

It is my belief that the National Health Service is no complete substitute for the School Dental Service with its intimate co-operation with the teaching staffs and its method of dental health education. Its final aim is prevention. No report on staffing can be complete without reference to the relative financial awards of the different branches of the dental profession and no doubt other branches can be made more attractive from this point of view. At the time of writing, the latest Whitley Award has been adopted by the County Council and one hopes that it is neither too little nor too late.

Premises and Equipment.

Further progress has been made in the re-equipping and modernising of dental surgeries. Colchester Culver Street Health Services Clinic, with two surgeries, awaits conversion from direct electric current to alternating and this is in hand. The new premises at Clacton are ready and the opportunity will be taken to put in new equipment here and likewise new equipment will be installed in the Clinic to be built at Harwich. The new premises at Colchester Shrub End are up to date and pleasant. At Romford Marks Road, structural alterations to enlarge the surgery are in hand and it is hoped that Hulse Avenue surgery (also in Romford) will undergo similar treatment in the next financial year. Several surgeries in other areas need attention to some degree. It is anticipated by the end of 1961/62 financial year the re-equipping programme will be about completed.

The current advances in high speed tooth cutting techniques are kept under constant review. The latest is that of a tiny turbine worked by compressed air, the speed of this machine being in the region of a quarter of a million revolutions per minute as against about 30,000 with the usual electrical equipment. The resulting minimal pressure of the drill on the tooth using this very high speed equipment makes for less discomfort to the patient. Arrangements are in hand to install a number of these machines on loan in different parts of the County before any final recommendation is made for general installation. It is to be noted that this will in no way make obsolete the equipment at present being installed. There is need for orthodox equipment as well as this " jet " apparatus.

Statistics.

During 1958, 86,218 children were inspected by the Committee's dental officers and of these 56,551 required treatment. Forty-eight thousand, three hundred and sixty-six were offered treatment and 37,256 were treated. The ratio of the number of permanent teeth filled to the number extracted due to dental disease is 4.6 : 1. This ratio last year was 5.1 : 1 and in 1956 5.5 : 1. This serious deterioration shows clearly the staffing situation. Children are presenting with toothache, and permanent teeth which should have been saved are being lost.

Orthodontics.

A consultant service is made available in the Saffron Walden area by the East Anglian Regional Hospital Board but the catchment area of the North East Metropolitan Regional Hospital Board is still without consultant cover. This is a matter of some importance as much valuable chairside time can be lost if wrong treatment planning of more complex cases occurs. The general situation still demands that a tight rein be kept on this form of treatment. An acceptable time is one session weekly per full-time officer. Nine hundred and thirty-four cases were completed by the staff compared with 1,074 cases last year and 944 in 1956.

General Anaesthetics.

Most of the Assistant County Medical Officers selected to attend the Eastman Dental Hospital for post-graduate instruction in the administration of nitrous oxide (dental) gas have completed the course and they are now attending the same institution for instruction in the administration of general anaesthetics other than nitrous oxide. This can be most useful especially in the treatment of young children. The scope of the service is increased and the time of the dental staff is saved for purely dental procedures when most of the general anaesthetics are given by the medical staff instead of by the dental staff. Eighteen thousand and forty-five administrations of general anaesthetics were carried out during the year.

Dental Appliances.

The dental laboratory at Barking, with four technicians and one apprentice, and the laboratory at Walthamstow, with two technicians, are kept fully occupied making dentures and orthodontic appliances. These are made for school children, expectant and nursing mothers and patients attending the Health Centres at Harold Hill and Aveley and the Executive Council dental centre at Walthamstow. A considerable amount of work is also let out to mechanics to the profession. Altogether 1,177 orthodontic appliances and 259 dentures were fitted for school children.

Dental Inspection.

Eighty-six thousand, two hundred and eighteen children were inspected and of these 23,912 attended as emergency cases, many of them seeking treatment for the relief of pain or other undesirable conditions. This number of emergency cases is far too high and is an indication of the service we are able to offer at present. With an adequate staff, most of these children would have been invited to accept treatment following routine school inspection and thus the trouble would have been prevented. It is a bad start to dental treatment for a young child when its first visit is for the extraction of teeth, and it is one which may well colour the whole of its future attitude to dentistry.

Dental Treatment.

A comprehensive service is available and the advanced form of treatment can be offered. It is a mistake, however, to undertake certain forms of treatment without consideration of the patient's history. In some cases the relief of pain is all that is appreciated and it is inviting disappointment to press other treatment on unwilling children. Due care should be taken to ensure as far as possible that patients to whom much time is given are appreciative and will attend regularly for treatment. It is accepted that only regular treatment is worth while and valuable time may easily be wasted in this way, time which could well have been spent on other children. During the 12 months under review 37,256 children were treated as compared with 38,323 in 1957.

Dental Health Education.

In accord with the axiom that prevention is better than cure and much less expensive, a fairly ambitious programme in dental health education is being undertaken. The chain to dental decay has three links, namely refined sugars and other carbohydrates, organisms and stagnation and if these three are present in the mouth then dental decay will almost inevitably occur. If any one of the three can be eliminated then the chain is broken and much decay can be prevented. The desirable end can be achieved by the correct use of the toothbrush, or if tooth brushing facilities are not available, then by finishing a meal with a cleansing food such as apples or celery. Regular visits to the dentist are also necessary. With this in view it is considered that the aims of dental health education should be to remove the fear of visiting the dentist, to demonstrate the clinging sticky caries-producing foods and the cleaning effect of fibrous foods and to instruct in the correct use of the toothbrush.

A dental health week was arranged at Braintree John Bunyan School in February, which has more or less become a pattern in the County. The teaching staff was most co-operative and brought the ideas into the children's lessons. Posters and instruction charts and leaflets were used and appropriate films were shown. The children were taken round an exhibition which had a dental surgery, a supply of caries-producing foods and cleansing foods, the effects of which were demonstrated and three-dimensional viewers showing the correct way to clean the teeth. Staff and Parent/Teacher Association meetings were very successfully arranged. Prior to the exhibition a clinical examination of the children was carried out and the state of oral hygiene assessed. The clinical examination was repeated six months after and the results indicated that valuable lessons had been learned. Further dental exhibitions and film shows have been held at 19 other places during the year, most of them by request.

At the request of the General Dental Council, the Committee have agreed that a five year dental health campaign shall be conducted in the New Town of Harlow. It is hoped to direct our attention to schools, maternity and child welfare clinics, industry and all youth organisations of the town. Up to now our endeavours have been directed to improving oral hygiene practices but this project goes a very important step further—it will try to assess change in the incidence of dental decay. There has been little work done in this field especially on this scale and the whole project could be of great interest and scientific value. The Ministry of Health has promised co-operation in the matter and one of their dental officers will carry out the clinical surveys on the same standard as that used in the fluoridation experiments.

In May the writer gave a lecture to the final-year students at the London Hospital Dental School on the subject of local authority dental services and this was followed by a visit to clinics in the Walthamstow, Romford and Forest Areas. The party was accompanied by the Dental Dean and some of the teaching staff of the hospital. The Committee also gave permission for students to attend in pairs at the Walthamstow Town Hall to observe the running of the Authority's dental treatment centre. This is now part of the final-year course and should prove useful to the students. It may also stimulate some interest in local authority work as a career.

A Committee has been set up under the chairmanship of Lord Adrian to study the amount of radiation received by patients from diagnostic radiology and that Committee has formed a Dental Panel. It has been agreed to co-operate in a survey to measure the radiation dose received by patients from dental x-ray sets. This is done by positioning an x-ray film in a special holder placed on the seat of a dental chair and a record is kept of the number of exposures and the number of patients over a given period. The x-ray film is then processed and an assessment is made. This work is also being carried on at Walthamstow.

Miss E. M. Knowles, O.B.E., F.D.S., Senior Dental Officer of the Ministry of Health, carried out a survey of the Local Health Authority's scheme for the treatment of expectant and nursing mothers and children under five years. She also carried out an inspection of all the dental clinics in the County. The visits started in August and were not completed until February 1959. Whilst the survey is not the direct concern of the Local Education Authority, it is of interest to note that the report on the premises and equipment is not unfavourable. The Minister also commends the campaign for the protection of dental health which the Council is undertaking and desires to be kept informed of its progress

The first school dental clinic in England was established in Cambridge in 1907 and in the first report of the Chief Medical Officer of the Board of Education (for the year 1908) occurs this statement—

> " The Board have viewed this experimental dental clinic with great interest, not only on account of its own merits but as an attempt to meet what is admitted on all hands to be a pressing need, namely, the appropriate treatment of the widespread evil of decaying teeth in school children. The importance and gravity of the question cannot be doubted."

After 50 years the importance and gravity of the situation are still very much apparent, indeed in some directions they have become greater.

J. BYROM.

Health Department,
County Hall,
Chelmsford.

4th June, 1959.

APPENDIX A

MEDICAL INSPECTION AND TREATMENT

RETURN FOR THE YEAR ENDED 31st DECEMBER, 1958

Part I.—Medical Inspection of Pupils Attending Maintained and Assisted Primary and Secondary Schools (including Nursery and Special Schools)

Table A.—Periodic Medical Inspections.

Age Groups Inspected (By year of birth) (1)	*No. of Pupils Inspected* (2)	*Physical Condition of Pupils Inspected*			
		Satisfactory		*Unsatisfactory*	
		No. (3)	*% of Col. 2* (4)	*No.* (5)	*% of Col. 2* (6)
1954 and later	887	870	98.1	17	1.9
1953	10,563	10,449	98.9	114	1.1
1952	10,777	10,651	98.8	126	1.2
1951	2,098	2,066	98.5	32	1.5
1950	723	705	97.5	18	2.5
1949	1,137	1,122	98.7	15	1.3
1948	3,262	3,233	99.1	29	0.9
1947	15,089	14,925	98.9	164	1.1
1946	7,333	7,254	98.9	79	1.1
1945	871	867	99.5	4	0.5
1944	5,034	5,012	99.6	22	0.4
1943 and earlier	15,609	15,531	99.5	78	0.5
TOTAL	73,383	72,685	99.0	698	1.0

Table B.—Pupils found to require Treatment at Periodic Medical Inspections (excluding Dental Diseases and Infestation with Vermin)

Age Groups Inspected (By year of birth) (1)	*For defective vision (excluding squint)* (2)	*For any of the other conditions recorded in Part II* (3)	*Total individual pupils* (4)
1954 and later	5	74	78
1953	180	1,169	1,291
1952	269	1,210	1,414
1951	63	253	300
1950	50	90	128
1949	96	108	193
1948	238	304	512
1947	1,043	1,852	2,745
1946	478	980	1,301
1945	61	91	142
1944	315	400	692
1943 and earlier	1,276	1,445	2,499
TOTAL	4,074	7,976	11,295

Table C.—Other Inspections.

Number of Special Inspections	33,899
Number of Re-inspections	36,067
Total	69,966

Table D.—Infestation with Vermin.

(a) Total number of individual examinations of pupils in schools by school nurses or other authorised persons	510,489
(b) Total number of individual pupils found to be infested	1,648
(c) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	28
(d) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	28

Part II—Defects Found by Medical Inspection During the Year

Table A.—Periodic Inspections.

Defect Code No.	*Defect or Disease*	PERIODIC INSPECTIONS							
		Entrants		*Leavers*		*Others*		*Total*	
		(*T*)	(*O*)	(*T*)	(*O*)	(*T*)	(*O*)	(*T*)	(*O*)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
4	Skin	222	347	386	294	504	311	1,112	952
5	Eyes—a. Vision	492	1,121	1,497	545	2,085	971	4,074	2,637
	b. Squint	264	231	46	62	136	137	446	430
	c. Other	73	82	49	64	142	151	264	297
6	Ears—a. Hearing	74	281	40	86	105	167	219	534
	b. Otitis Media	65	292	36	93	45	149	146	534
	c. Other	52	100	53	57	63	71	168	228
7	Nose and Throat	564	2,069	108	210	310	811	982	3,090
8	Speech	238	396	13	41	77	130	328	567
9	Lymphatic Glands	31	525	4	45	27	153	62	723
10	Heart	37	324	34	166	80	318	151	808
11	Lungs	249	670	68	163	216	408	533	1,241
12	Developmental—								
	a. Hernia	30	84	6	12	19	33	55	129
	b. Other	51	371	48	100	203	458	302	929
13	Orthopaedic—								
	a. Posture	86	210	245	203	476	464	807	877
	b. Feet	271	481	144	187	367	368	782	1,036
	c. Other	280	660	197	337	448	654	925	1,651
14	Nervous System—								
	a. Epilepsy	13	52	11	30	31	39	55	121
	b. Other	22	125	16	42	43	124	81	291
15	Psychological—								
	a. Development ...	43	223	12	38	56	191	111	452
	b. Stability	66	493	19	75	104	314	189	882
16	Abdomen	21	98	15	33	26	82	62	213
17	Other	147	122	258	96	491	231	896	449

Table B.—Special Inspections.

Defect Code No. (1)	*Defect or Disease* (2)	*Special Inspections* *Pupils requiring Treatment* (3)	*Pupils requiring Observation* (4)
4	Skin	4,096	223
5	Eyes—		
	(a) Vision	1,082	454
	(b) Squint	67	24
	(c) Other	690	102
6	Ears—		
	(a) Hearing	334	105
	(b) Otitis Media	114	51
	(c) Other	265	42
7	Nose and Throat	886	309
8	Speech	488	163
9	Lymphatic Glands	41	46
10	Heart	53	101
11	Lungs	235	192
12	Developmental—		
	(a) Hernia	11	9
	(b) Other	119	111
13	Orthopaedic—		
	(a) Posture	154	54
	(b) Feet	307	97
	(c) Other	904	210
14	Nervous System—		
	(a) Epilepsy	21	27
	(b) Other	119	96
15	Psychological—		
	(a) Development	199	117
	(b) Stability	230	161
16	Abdomen	61	18
17	Other	3,244	866

Part III—Treatment Tables

Table A.—Eye Diseases, Defective Vision and Squint.

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	3,132
Errors of refraction (including squint)	16,048
Total	19,180
Number of pupils for whom spectacles were prescribed	10,812

Table B.—Diseases and Defects of Ear, Nose and Throat.

	Number of cases known to have been treated
Received operative treatment—	
(a) for diseases of the ear	47
(b) for adenoids and chronic tonsillitis	2,221
(c) for other nose and throat conditions	121
Received other forms of treatment	2,464
Total	4,853
Total number of pupils in schools who are known to have been provided with hearing aids—	
(a) in 1958	49
(b) in previous years	119

Table C.—Orthopaedic and Postural Defects.

(a) Pupils treated at clinics or out-patient departments	4,296
(b) Pupils treated at school for postural defects	39
Total	4,335

Table D.—Diseases of the Skin (excluding uncleanliness, for which see Table D of Part I).

	Number of cases known to have been treated
Ringworm—	
(i) Scalp	16
(ii) Body	7
Scabies	14
Impetigo	172
Other skin diseases	5,212
Total	5,421

Table E.—Child Guidance Treatment.

Pupils treated at Child Guidance Clinics	1,619

Table F.—Speech Therapy.

Pupils treated by Speech Therapists	2,705

Table G.—Other Treatment Given.

(a) Pupils with minor ailments	7,560
(b) Pupils who received convalescent treatment under School Health Service arrangements	526
(c) Pupils who received B.C.G. Vaccination	10,166
(d) Other than (a), (b) and (c) above	
Enuresis	98
Total	18,350

Part IV—Dental Inspection and Treatment Carried out by the Authority

(1) Number of pupils inspected by the Authority's Dental Officers—

(a) At Periodic Inspections	62,306
(b) As specials	23,912
Total	86,218

(2) Number found to require treatment	56,551
(3) Number offered treatment	48,366
(4) Number actually treated	37,256
(5) Number of attendances made by pupils for treatment (including that recorded at 11 (h) below)	111,800
(6) Half days devoted to—	
(a) Periodic (School) Inspection	1,133
(b) Treatment	16,392
Total	17,525
(7) Fillings—	
(a) Permanent Teeth	53,831
(b) Temporary Teeth	18,502
Total	72,333
(8) Number of teeth filled—	
(a) Permanent Teeth	48,589
(b) Temporary Teeth	17,489
Total	66,078
(9) Extractions—	
(a) Permanent Teeth	10,455
(b) Temporary Teeth	34,207
Total	44,662

(10) Administration of general anaesthetics for extraction	18,045
(11) Orthodontics—	
(a) Cases commenced during the year	1,463
(b) Cases carried forward from previous year	1,887
(c) Cases completed during the year	934
(d) Cases discontinued during the year	448
(e) Pupils treated with appliances	2,116
(f) Removable appliances fitted	1,177
(g) Fixed appliances fitted	43
(h) Total attendances	13,570
(12) Number of pupils supplied with artificial teeth	259
(13) Other Operations—	
(a) Permanent Teeth	*24,399
(b) Temporary Teeth	9,882
Total	34,281

* including 1,109 operations carried out by oral hygienists.

APPENDIX B

CAUSES OF DEATH BY SEX IN AGE GROUP 5—14 YEARS 1956, 1957 AND 1958

Cause of death	*Male*			*Female*		
	1956 (2)	1957 (3)	1958 (4)	1956 (5)	1957 (6)	1958 (7)
(1)						
1. Tuberculosis—respiratory	–	–	–	–	–	1
2. Tuberculosis—other	–	–	–	1	–	1
3. Syphilitic disease	–	–	–	–	–	–
4. Diphtheria	–	–	1	–	–	–
5. Whooping cough	–	–	–	–	–	–
6. Meningococcal infections	–	–	–	2	–	–
7. Acute poliomyelitis	2	1	–	–	1	–
8. Measles	–	–	–	–	1	–
9. Other infective and parasitic diseases	–	3	1	–	1	–
10. Malignant neoplasm, stomach	–	–	–	–	–	–
11. Malignant neoplasm, lung and bronchus	–	–	–	–	–	–
12. Malignant neoplasm, breast	–	–	–	–	–	–
13. Malignant neoplasm, uterus	–	–	–	–	–	–
14. Other malignant and lymphatic neoplasms	8	3	10	4	5	3
15. Leukaemia and aleukaemia	6	3	2	5	2	5
16. Diabetes	–	–	–	–	–	–
17. Vascular lesions of the nervous system	–	–	–	1	–	–
18. Coronary disease, angina	–	–	–	–	–	–
19. Hypertension with heart disease	–	–	–	–	–	–
20. Other heart disease	1	–	–	1	1	–
21. Other circulatory disease	1	–	–	–	–	–
22. Influenza	–	2	1	1	5	2
23. Pneumonia	6	2	1	2	4	4
24. Bronchitis	1	2	–	1	1	1
25. Other diseases of the respiratory system	–	5	1	2	2	5
26. Ulcer of stomach and duodeum	–	–	–	–	–	–
27. Gastritis, enteritis and diarrhoea	–	–	–	–	–	1
28. Nephritis and nephrosis	3	4	2	–	1	1
29. Hyperplasia of prostate	–	–	–	–	–	–
30. Pregnancy, childbirth, abortion	–	–	–	–	–	–
31. Congenital malformations	4	7	5	2	8	7
32. Other defined and ill-defined diseases	16	14	10	8	6	13
33. Motor vehicle accidents	8	13	7	2	3	3
34. All other accidents	10	8	14	2	1	1
35. Suicide	1	1	–	–	–	–
36. Homicide and operations of war	1	1	–	–	–	–
ALL CAUSES	68	69	55	34	42	48

B.C.G. VACCINATION OF SCHOOL CHILDREN—1958

Division (1)	Number of children offered vaccination (2)	Number accepting (3)	Percentage acceptance rate (4)	Positive Reactors at preliminary test		Number of children receiving B.C.G. vaccination (7)	Cases of post-vaccinal complications (8)
				Number (5)	Percentage (6)		
North-East Essex	1,907	993	52.1	159	16.0	777	–
Mid-Essex	1,294	1,294	100.0	225	17.4	1,069	–
South-East Essex	1,585	684	43.1	68	9.9	616	–
South Essex	4,259	2,179	51.2	250	11.5	1,797	–
Forest	2,681	1,447	54.0	115	7.9	1,305	–
Romford	1,797	828	46.1	82	9.9	702	–
Barking	1,109	723	65.2	75	10.4	648	–
Dagenham	2,186	851	38.9	77	9.0	588	–
Ilford	3,998	1,295	32.4	90	6.9	1,109	–
Leyton	1,448	606	41.8	46	7.6	560	
Walthamstow	2,147	1,126	52.4	131	11.6	995	1
TOTAL	24,411	12,026	49.3	1,318	10.9	10,166*	1

* i.e. 94.9 of negative reactors

TONSILLECTOMY RATES—1958

Age group (1)	*Sex* (2)	*Number inspected* (3)	*Number found to have undergone Tonsillectomy* (4)	*Percentage found to have undergone Tonsillectomy* (5)
5 years	Boys	12,077	764	5.7
	Girls	11,634	597	
10—12 + years	Boys	12,749	2,137	16.6
	Girls	12,456	2,043	
14 years	Boys	9,318	1,348	13.8
	Girls	8,747	1,149	

Division (1)	Number of school entrants examined (2)	Number of school entrants who have had tonsillectomy (3)	Percentage (4)	Number of children aged 10-12 and 14 years examined (5)	Number of children aged 10-12 and 14 years who have undergone tonsillectomy (6)	Percentage (7)	Number of children known to have received operative treatment for adenoids and chronic tonsillitis (8)	Percentage of school population (9)
North-East Essex	2,504	135	5.4	5,203	838	16.1	391	1.44
Mid-Essex	2,783	44	1.6	1,671	45	2.7	135	0.42
South-East Essex	1,229	53	4.3	2,950	325	11.0	210	0.85
South Essex	4,748	527	11.1	6,960	1,683	24.2	538	1.12
Forest	3,630	130	3.6	4,951	152	3.1	44	0.11
Romford	2,024	149	7.4	4,320	872	20.2	301	1.34
Barking	958	45	4.7	2,536	500	19.7	99	0.75
Dagenham	1,441	49	3.4	3,904	197	5.0	118	0.56
Ilford	2,119	113	5.3	4,886	1,146	23.4	392	1.64
Leyton	890	54	6.1	2,157	380	17.6	—	—
Walthamstow	1,385	62	4.5	3,732	539	14.4	37	0.19

Incidence of psychological conditions amongst pupils and their referral to Child Guidance Clinics

(1)	1950 (2)	1954 (3)	1958 (4)
(1) Total school population	207,893	251,989	281,800
(2) Number of children undergoing routine periodic medical inspection.	66,085	77,073	73,383
(3) Number of such children requiring treatment for a psychological condition	159 (2.4 per thousand inspected)	258 (3.3 per thousand inspected)	300 (4 per thousand inspected)
(4) Number of children found at special medical inspections to require treatment for a psychological condition.	245	273	429
(5) Number of children at routine and special medical inspections requiring observation for psychological conditions.	798	1,172	1,612
(6) Total number of children requiring treatment or observation.	1,202 (5.7 per thousand school population)	1,703 (6.7 per thousand school population)	2,341 (8.3 per thousand school population)
(7) Number of such children referred to child guidance clinics.	739 (61.5%)	893 (52.4%)	1,483 (62.5%)
(8) Number awaiting diagnosis on 31st December, 1958.	461	281	397
(9) Number awaiting treatment on 31st December, 1958.	32	64	168

Handicapped pupils requiring Special Educational Treatment—

Prevalence per 1,000 school children

Year	*School Population*	*Blind*	*Partially Blind*	*Deaf*	*Partially Deaf*	*Delicate*	*Physically Handicapped*	*Educationally Sub-normal*	*Mal-adjusted*	*Epileptic*
1950	207,893	0.22	0.28	0.52	0.37	2.25	1.38	4.00	0.73	0.13
1951	218,514	0.23	0.30	0.61	0.26	2.33	1.35	4.52	0.80	0.12
1952	231,477	0.24	0.25	0.59	0.32	2.09	1.57	4.43	0.95	0.16
1953	242,037	0.25	0.27	0.52	0.32	1.92	1.45	4.65	0.93	0.14
1954	251,989	0.23	0.27	0.53	0.32	1.91	1.75	4.73	0.95	0.12
1955	261,620	0.22	0.27	0.46	0.34	1.74	1.60	4.55	0.95	0.12
1956	270,295	0.23	0.27	0.43	0.32	1.48	1.41	4.88	0.99	0.14
1957	277,044	0.23	0.25	0.39	0.32	1.54	1.47	5.34	1.05	0.13
1958	281,800	0.21	0.26	0.36	0.34	1.62	1.51	5.40	1.06	0.14

SUMMARY OF HANDICAPPED PUPILS—1958

Category	Newly placed in special schools or homes	Newly assessed as needing special educational treatment at special schools or in Boarding Homes	Number attending special schools		Attending Independent Schools	Number boarded in homes	Educated under arrangements made under Sec. 56		Number remaining unplaced	
			Day Pupils	Boarding Pupils			At home	In Hosp.	Day	Residential
Blind	8	5	—	46	1	–	3	—	—	8
Partially sighted	8	11	35	30	—	—	1	—	1	6
Deaf	10	10	51	37	12	—	—	—	—	2
Partially Deaf	11	10	59	23	9	—	—	—	2	3
Delicate	193	200	205	154	17	4	6	20	7	44
Physically Handicapped	79	71	201	77	12	1	48	60	7	21
Educationally sub-normal	338	308	890	321	38	–	26	—	171	77
Maladjusted	72	95	—	123	105	17	5	—	1	49
Epileptic	7	12	5	28	—	—	—	6	—	8
Speech defect	—	—	—	4	—	—	—	—	—	2
	726	722	1,446	943	194	22	89	86	189	220
									(409) (49 patients refused)	

APPENDIX C

Replacement of the Intermediate Routine Medical Inspection by a Modified System

Report by Dr. R. E. Barrett, School Medical Officer

In 1957 a new system of medical supervision was introduced experimentally at St. George's School and St. John's Green Junior School in the North-East Essex Division. The system has been in operation for over a year now and a review of the results obtained is now due. I have discussed this Report with Dr. Macmillan who, with Miss Knight, Superintendent Health Visitor, and myself was jointly concerned in preparing and implementing the scheme, and she has expressed her general agreement with its findings and conclusions. As Miss Knight has pointed out in discussion, its possible extension to other schools in this Division will necessarily be limited by staff considerations and may, I understand, involve questions of organisation and establishment in the School Nurse cadre—questions which are outside the scope of this Report.

Whatever its technical merits or demerits, it can confidently be said that the system was initiated and has been operated throughout the period under review without disturbance to school routine and with the willing co-operation of teaching staff and parents alike. Credit for this is due mainly to Mrs. Blight and Miss Jeffery, School Nurses of St. George's and St. John's Green Schools, respectively, who did most of the work summarised in this Report.

Briefly, the procedure consisted of a screening inspection by the School Nurse with the child stripped to the waist and barefooted, with the mother present if possible. Children suspected to be defective were referred to the School Medical Officer for further investigation, but obvious dental and visual acuity defects were referred by the nurse directly to the dental and eye clinics. The figures under the " Observation " and " Treatment " headings include children referred to the Medical Officer and placed in the appropriate category. Children referred for specialist investigation are included in the " Treatment " heading.

Two age groups were inspected during the year, namely 8 and 10-year-olds at St. John's Green School and 9 and 10-year-olds at St. George's School. The results of these examinations are set out in Tables I and II.

A composite group of routine medical inspection results carried out in Colchester Schools by three medical officers during 1957 are included in the tables.

They comprise children of all three age groups and although not truly comparable with the School Nurses' results (which were, as stated, confined to the intermediate age groups), they are used, *faute de mieux,* as an approximate standard of comparison.

From Table I it will be seen that there is no material difference in the overall totals of recorded defects between the Medical Officers' routine inspection results on the one hand and those of the School Nurses on the other. But analysis of the pattern of defects shows considerable difference between the two sets of figures (Table II). It will be seen here that psychological and E.N.T. defects were more frequently recorded and orthopædic defects (mainly postural) less frequently recorded by the Medical Officers than by the Nurses. From this it might be deduced that the Medical Officers gave relatively greater attention than the Nurses to history and subjective symptoms while the latter relied more on visual observation.

Much of the ill-health now met with in school-children in the course of routine medical inspection is dependent for its recognition, largely or even entirely, on a history of symptoms or behaviour abnormality given by the parent or teacher. The reasons for this are twofold. In the first place, the incidence of the grosser and more obvious manifestations of physical disease is much lower than it used to be because of improved access to medical facilities and generally improved living standards ; this necessitates greater dependence on symptoms as a pointer to early departures from health. Secondly, greater attention is now being paid to psychological disorders in children and there is growing recognition of the importance of its early detection and treatment. If a child on visual inspection looks healthy and normally developed physically and mentally, and is thought to be so by the parent of average intelligence and to the teacher with whom the child is in daily contact, the probabilities are that the child is in fact healthy. In any health screening procedure, therefore, it is desirable that the school nurse should, in addition to visual inspection, question the parent and teacher either by use of a set questionnaire or other suitable means. When replies, either written or verbal, point to the likelihood of a defect being present, the School Nurse will not examine the child herself, but will refer him to the School Medical Officer for further investigation.

A health interview conducted by the School Nurse in this manner, that is to say by visual inspection supplemented by questioning the parent and teacher, will, it is thought, greatly improve the efficiency of the system and should yield results comparable statistically with those obtained in the course of routine medical inspections carried out directly by the School Medical Officer.

TABLE I

	Examined	Excl. V and D defects		Vis. and Dent. Obs. & Tr.		Total Defects	Percentage of defects to Nos. Exam. (Excl. V.A. and dental defects)	Percentage of treated defects to Nos. Exam. (excl. V.A. and dental defects)
		Obs.	Tr.	Vis.	Dent.			
Routine, all groups (Drs. Macmillan, Singer, Barrett, 1957)	444	136	21	24	62	243	35.4	4.7
Miss Jeffrey's, November, 1957	143	44	11	1	35	91		
do. July, 1958	60	6	2	6	22	36		
do. TOTAL	203	50	13	7	57	127	31.0	6.4
Mrs. Blight, October, 1957	178	88	6	8	62	164		
do. June, 1958	151	52	6	3	38	99		
do. TOTAL	329	140	12	11	100	263	46.2	3.6
Total School Nurses	532	190	25	18	157	390	40.4	4.7

TABLE II

	Nurses		*Medical Officers*	
	Number	*Percentage*	*Number*	*Percentage*
Examinations	532	—	444	—
Defects	215	40.4	157	35.4
Orthopædic	108	20.3	43	9.7
E.N.T.	16	3.0	31	7.0
Psychological	10	2.0	26	6.0
Skin	24	4.5	16	3.6
Respiratory	4	0.8	7	1.6
Speech	3	0.6	3	0.7
Development	1	0.2	7**	1.6
Other	49	9.2	24	5.4

**Obesity	3
Imperfect descent testes	3 (infants only)
Varicocele	1 (3rd exam.)

APPENDIX D

A Diphtheria Outburst in the Barking Division reported by Dr. F. Groarke, Medical Officer of Health/Divisional School Medical Officer and Dr. M. I. Adamson, School Medical Officer, Barking.

Not so long ago diphtheria was a prevalent killer disease but nowadays it tends to produce local epidemic outbursts only. Such outbreaks can be troublesome to control because of the presence of human chronic carriers, themselves immune to the disease, who act as reservoirs of infection to the susceptible young members of the community.

The local epidemic now described occurred in Barking, Essex during September and October, 1958.

On the morning of 30.9.58 the Health Department was notified by a local isolation hospital that a diagnosis of diphtheria had been arrived at in the case of two Barking infant school children.

The following details were obtained.

Case I. A boy of 7 years, fifth in a family of eight children, was taken ill on return from school on 19th September. He was treated at home as a case of tonsillitis for four days and received antibiotic therapy, but he failed to make a good response and on 24th September he was admitted to an Isolation Hospital. Routine nose and throat swabs on admission failed to reveal the presence of C.diphtheriæ. He appeared to be making satisfactory progress during the next few days, when on 29th September he became pale, lethargic and collapsed with an irregular pulse and marked electrocardiographic abnormalities. The diagnosis of diphtheria was now made on clinical grounds in the absence of laboratory confirmation. This boy died on September 30th.

Case II. A girl of six years, a close friend and classmate of Case I, and fourth in a family of seven children, was taken ill with sore throat on 25th September, and was seen and treated for tonsillitis with antibiotics on 27th September. She was admitted to hospital on 29th September where she was found to be very ill, with "bull neck", pharyngeal exudate, and cardiac involvement. An E.C.G. showed Bundle Branch Block. Diphtheria was diagnosed immediately and anti-toxin administered, together with cortisone therapy. This child was extremely ill for some days but eventually recovered. No bacteriological confirmation of the diagnosis could be obtained in this case either.

The school class in which the two cases occurred was one of four in a modern single storey infants school with 127 pupils aged between five and seven years in attendance. The children for the most part kept to their own classes but mixed together during playtime, assembly and for certain instruction, e.g. singing lessons. Adjoining this school, separated by a wooden fence, are boys' and girls' secondary schools whose 1,000 pupils are drawn from the same catchment area. The infants share the senior school dining room.

Cases I and II both stayed to school dinners.

Immunisation state. The class concerned in the infant school contained 35 pupils born between 1952 and 1953, and of these 17 were known to have been immunised by the immunisation record cards held in the Health Department, 11 were said never to have been immunised, while no record cards were held for the remaining seven pupils whose parents could not remember whether or not diphtheria immunisation had been carried out. Taking the school as a whole 60 of the 132 pupils were immunised, 48 had never been immunised, and the position regarding the remaining 24 pupils was in doubt. No immunisation record card could be found for either of the two cases.

On the day of notification teams of doctors and health visitors inspected the throats and took swabs from about 100 contacts of the children including the rest of the class and the patients' families and close contacts. No further suspected cases were revealed by this examination, and apart from one doubtful positive swab from an older brother of a boy in the class, all the swabs were negative for C.diphtheriæ.

While awaiting the swab results, Schick testing was carried out on 31 pupils in the affected class because some five years or so had elapsed in some cases since primary immunisation and in other cases the immunisation state was unknown.

Case III. On 4th October an unimmunised girl from the same class developed a sore throat. She had been under observation as a contact and was admitted to hospital on the same day without home treatment. Antitoxin was given at once and she was never seriously ill. Virulent gravis organisms were grown from her throat swabs after admission. The swabs taken before she became ill had been negative.

Case IV. The next day another six year old girl from the class was found on a routine visit to be suffering from sore throat with slight exudate on both tonsils. She was admitted to hospital where she was given antitoxin. The diagnosis was subsequently confirmed bacteriologically. She suffered a mild attack only. This patient had received a single dose of a combined diphtheria and whooping cough vaccine over five years before.

As a result of this development, it was decided to close temporarily the affected class and to administer prophylactic serum to its nine remaining Schick positive members. It was also decided to re-swab the affected class and home contacts and to Schick test and swab the pupils in the remaining three classes of this school. The school staff was included in the investigations.

Case V. On 7th October diphtheria was diagnosed in a girl of 12 years whose brother was class mate of the four known cases. This boy had already been swabbed twice and proved negative, yet a repeat swab taken on 7th October was positive, but although he was never immunised according to available records, he did not develop the disease, perhaps because he had been given prophylactic serum two days before when his Schick test was found to be positive. His sister had never been immunised either and had a severe attack, from which she eventually made a good recovery. She had not been to school since 29th September, but fortunately no cases or carriers were revealed amongst her classmates on routine inspection and swabbing.

More carriers were now being detected including the original doubtful positive swabbed on the first day, and three more members of his family, including his mother, whose swabs were previously negative. The second sweep through the affected class revealed three carriers amongst the pupils, two of whom had received prophylactic serum a few days earlier as a result of the Schick test.

Hospital treatment was arranged for the treatment of carriers, but as the demand for beds for cases, suspected cases and carriers grew, accommodation became scarce, and it was decided to isolate and treat healthy carriers at home where conditions permitted, and with the co-operation of the family doctors.

Despite the fairly close contact with the pupils in the affected class swabbing of the pupils in the three unaffected classes did not bring to light any further carriers. The Schick testing revealed that 28 pupils in the remaining classes were susceptible and it was decided to protect these children by the simultaneous administration of antitoxin and antigen, a procedure suggested by Downie et al (1948 Journal of Hygiene, 46, 34). A.P.T. was chosen despite the slight risk of provoking poliomyelitis (Lancet, 1956, 11 1223), because at the time the district was free of this disease, and it was considered that a potent antigen such as A.P.T. is more likely to lead to a satisfactory level of immunity in the presence of small amounts of antitoxin.

The outbreak stimulated a marked increase in demand for diphtheria immunisation, and approximately 1,800 children were immunised or received a booster dose of antigen within the few weeks of the epidemic. T.A.F. or F.T. was used in all cases except for the close contacts who received prophylactic serum and A.P.T.

Cases VI and VII. On 10th October two older siblings of one of the carriers in the class were found also to have positive throat swabs. Both had slight sore throats with scanty exudate when seen at home. They were admitted to hospital and later notified as cases of diphtheria although the clinical diagnosis was considered by the Physician-in-Charge to be rather doubtful. Both had been immunised in the past (one of them not for 8 years) and they had mild attacks.

Case VIII. Also on 10th October a sister of Case V, aged 8 years, developed a sore throat and was sent to hospital as a suspected case of diphtheria. Bacteriological confirmation was later obtained. She was under observation and was detected at an early state. She had not been immunised, but was not severely affected.

Case IX. The only patient not of school age was now detected. A boy of two years was admitted to hospital on 9th October with inflamed tonsils sparsely covered with exudate. The diagnosis was confirmed bacteriologically later. He was bright and active all along and was never very ill. His sister attended the affected school, but was in a different class. He lived in the area from which most of the cases and carriers were found. This boy's father, a labourer, and the sister referred to above, were subsequently found to be carriers, and treated at home.

Case X. This patient was sent to hospital for treatment as a carrier and presented a diagnostic problem to the clinicians who notified him eventually as a mild faucial diphtheria. He was a member of the affected class who had never been immunised and was found on 3rd October to be Schick positive. Two days later he was given prophylactic serum. A repeat routine swab taken on 7th October was found to be positive and he was admitted to hospital. His condition was satisfactory throughout. His Uncle who worked as a bus conductor and lived in the same house was found to be a carrier and was successfully treated at home before resuming his employment.

Case XI. The source of infection introduced to the class before 19th September was never discovered and things were settling back to normal when an interesting development occurred. A boy of six years from the affected class where he sat next but one to Case No. I was last at school on September 12th, the term commencing on 8th September after the summer holidays. Symptoms of sore throat and difficulty in swallowing developed soon after return from school and his neck gradually became swollen. A locum doctor who saw the boy on 15th was said to state that the boy was suffering from mumps and "coccol" throat. Notes were made on the boy's medical record card on 24th September read "very severe streptococcal throat infection with oedema. Made very satisfactory recovery with Penicillin, M. and B., Antinomycin (not all at once)". This boy was medically examined including an E.C.G. and swabbed several times subsequently without producing evidence of diphtheria, when on 22nd October about six weeks after his illness from which he had apparently made a full recovery the boy returned to his doctor with paralysis of the palate of both sides. He was admitted to hospital and notified as diphtheria (faucial—missed case). He made a very satisfactory recovery in a few weeks. Further investigation did not reveal the source of this boy's infection.

In all, in addition to the 11 cases described, 15 carriers were detected. All but three of these 26 patients either were in the class, had a sibling in the class or were very closely associated with a known case or carrier. Three adult carriers were detected and only one of the patients was under school age. The 22 school children involved attended six schools in all. Routine swabbing was carried out on all pupils at the infants school and on the 1,000 pupils of the adjoining senior schools. Pupils attending five classes in four other schools who might have been contacts of the cases or carriers were also swabbed. Bacteriological investigation of the mass swabbings was carried out by the London County Hall, Public Health Laboratory, and of approximately 3,000 swabs submitted only two carriers were discovered who could not be considered to be closely associated with any of the known cases or carriers. This small number found in what might be regarded as the general community of school children supports the supposition that it is rare nowadays to find carriers except amongst persons closely associated with an outbreak.

The bacteriology associated with the close school and community contacts was carried out by the laboratory attached to the local isolation hospital where with the exception of cases 1 and 2 who had been treated at home with antibiotics for several days prior to admission to hospital, and case II who also received antibiotic therapy and was only considered to be a case when the complication of Palatal paralysis was discovered several weeks later, all the cases and carriers detected were found to be infected with a virulent gravis strain C.diphtheriæ.

In all, some 4,000 swabs from 1,000 persons were submitted for examination and a vast amount of work was carried out by the medical, nursing and administrative staffs in following up contacts and keeping them under observation.

Previous Immunisation History.

One of the patients aged 13 years (Case VI) had a full course of immunisation in 1946 with a booster dose in 1950 and his brother aged 10 years (Case VII) completed immunisation in 1950 and had a booster injection in 1954. In both cases the illness was so slight that there was some doubt regarding the diagnosis. Two other children had begun a course of primary immunisation 5 and 7 years previously and had not completed it. No immunisation record cards could be found for the remaining seven cases including the original two cases. Nine of the carriers, including two sisters of Cases VI and VII, had been immunised at some time. Three others, carriers who had never been immunised, had been protected by prophylactic serum. Three adult carriers were detected.

Protection Methods.

When the fourth case arose in the affected class, nine pupils in the same class, as a result of the Schick test were given 8,000 units anti-toxin in order to prevent further spread amongst the exposed unprotected children. 0.5 c.c. A.P.T. was given two weeks later to this group and repeated in a further six weeks. Three months later a post Schick test was performed on five of these children when all were now found to be Schick negative.

In the remaining classes at the affected school, 28 pupils received simultaneously 500 units anti-toxin in one arm and 0.5 c.c. A.P.T. in the other. Six weeks later the group received a repeat dose of A.P.T. Three months later 22 members of this group were Schick tested and all were found to have converted to Schick negative.

Anaphylactic Reactions.

Anti-toxin treatment was followed in two cases by fleeting urticarial eruptions. There were no other sequelae.

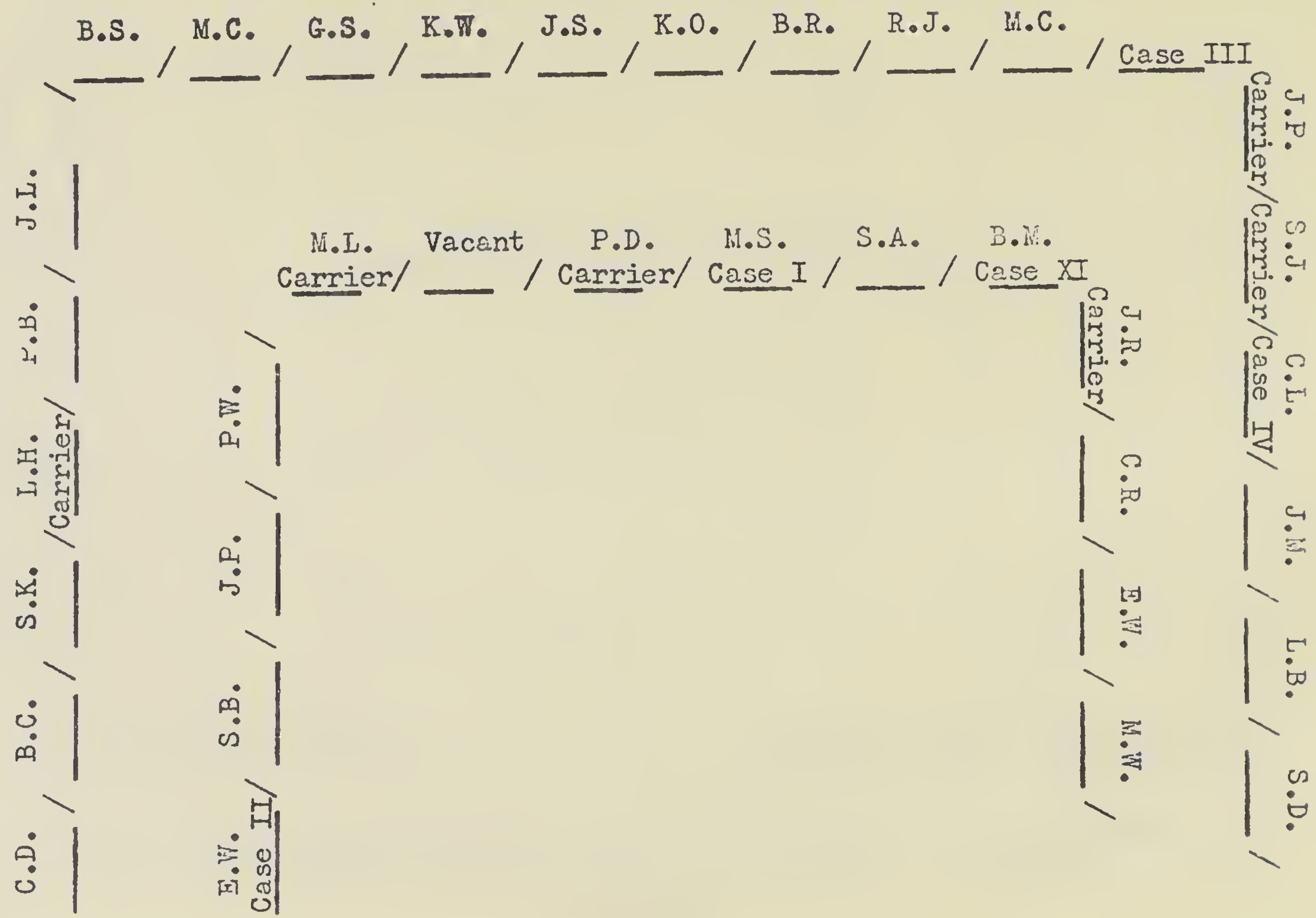
Treatment of Carriers.

Eight carriers were treated at home and the remainder received hospital treatment. Sensitivity tests were carried out in each case before treatment commenced. In all cases the organisms were found sensitive to sulphanilamide, penicillin, erythromycin, tetracycline and other antibiotics. Four patients were given orally tablets combining 120 mgm penicillin, and 0.88 G sulphanilamide 4 hourly for 4 days. On re-swabbing 3 days after completion of this course, 2 of the 4 were found to remain positive. Two children received oral penicillin alone, 125 mgm 6 hourly for 4 days ; one did not respond. Erythromycin in doses of 200 mgm 6 hourly for 4 days, was given as the initial treatment in one case, a brawny labourer, with success, and in three cases where the primary course with other medicaments had failed. In two cases this sufficed to effect a cure, but one case failed completely to respond to penicillin initially, then Erythromycin and finally 250 mgm Terramycin 6 hourly for 4 days. He was eventually seen by a Consultant Ear, Nose and Throat Surgeon who enucleated his tonsils and adenoids. This operation effectively cured the carrier condition.

We are indebted to the various members of staff whose vigilance over several weeks made possible the early ascertainment and successful treatment of several cases of gravis diphtheria, and whose efforts undoubtedly led to the control of the outburst. We should like also to thank family doctors and hospital staffs, and in particular Laboratory personnel, for their ready help and full co-operation throughout the epidemic.

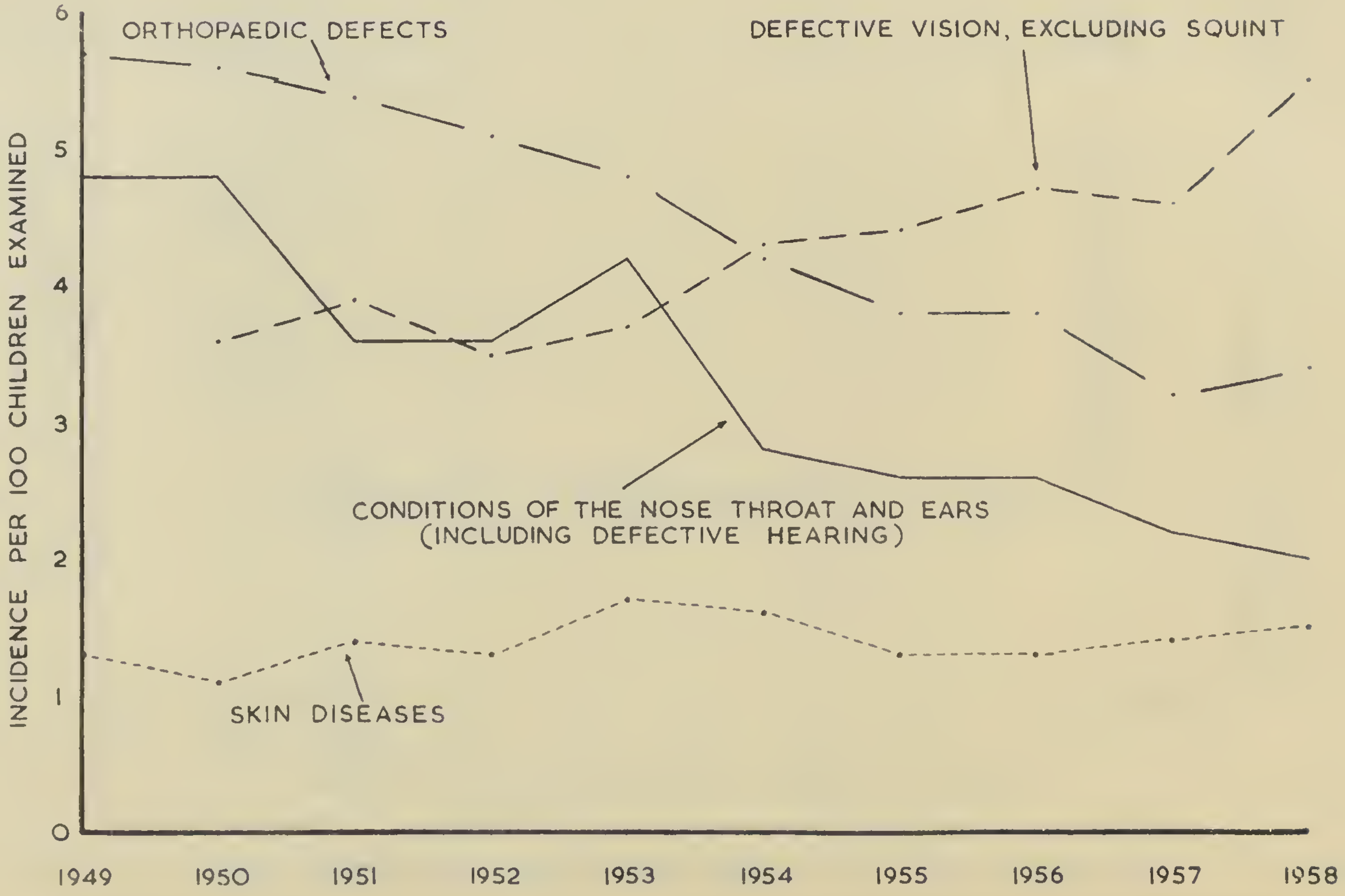
DIPHTHERIA OUTBREAK, BARKING: SEPT.—OCT., 1958

Plan of the Seating Arrangements of the Pupils in the Affected Infant School Class showing the position of the Detected Cases and Carriers



APPENDIX E

Certain conditions found at Routine Medical Inspections to require treatment



APPENDIX F

Routine Audiometric Testing of School Children in North East Essex Division

Dr. R. E. Barrett—School Medical Officer reports :—

" During the winter 1957-58, an audiometric sweep survey was carried out on 436 children attending infant and junior schools in Colchester. The sound intensity used was 20 decibels for infants, i.e. children from 4 years and 9 months to 5 years of age, and 15 decibels for children from 7 to 10 years of age. The c.p.s. levels selected were 500, 1000, 2000, 4000 and 6000. Each ear was tested and the criterion of failure was inability to hear at more than one c.p.s. level in either ear. Most children who failed were retested 2-3 months after the initial test. In a few cases, this was not possible because they were absent from school when the retest was done. The results are set out in Table I.

2. The majority of children audiometrically tested were clinically (and auriscopically) examined for the presence of E.N.T. defects. The records of these examinations are only available for those who failed the second test or who, having failed the first test, were not subsequently retested. The results of the clinical examinations are given in Table II.

3. By " clinical history " and " physical signs " is meant a history or physical signs indicative of E.N.T. defect or dysfunction, past or present, including a report by the teacher of defective hearing at school. Most of these examinations were carried out at school and the parents were not present for consultation ; but where the clinical findings warranted, a special appointment was made for the parent and child to attend the clinic for a fuller examination. In this way, 6 children were referred for specialist investigation. With regard to the heading " no history of physical signs " it is probable that fewer children would have been so listed had the parents been present for consultation at every clinical examination.

4. From Table I it will be seen that of 436 children tested, 69 failed to pass one test and of 58 first failures subjected to a second test two to three months later, 27 failed. Of 36 children (second failures, plus first failures, not retested) clinically examined, 23 gave a history or showed clinical evidence of E.N.T. defect or dysfunction, past or present (Table II) but specialist examination might well have yielded a higher figure. Of the pathological conditions, naso-pharyngeal catarrh or infection with involvement of the tonsils or adenoids was most frequently recorded. No case of suppurative otitis media with patent perforation was met with in this series, but at least two children showed evidence of a healed perforation. As already mentioned, only 6 children had defects sufficiently

advanced as to necessitate immediate referral to the E.N.T. Clinic. The remainder were noted for observation in the expectation that the defect would spontaneously resolve. Evidence of deafness given by the teacher was not frequent and no child in the series was found to be so defective in hearing as to justify any special measures other than to arrange for a front position in class.

5. Thirteen children gave neither definite history nor yielded physical signs of E.N.T. defect, but as mentioned above, the parents were not usually present for questioning. The group comprised 7 juniors and 6 infants. The 7 juniors were clinically examined again about 6 months after the examination referred to in Table II. Except for one boy (adopted, maladjusted) who complained of occasional left earache, the results were again negative. An audiometric retest was not done as the instrument had by that time been sent to another district. None of the 6 infants in this group have yet been re-examined. Three of them are stated by the teachers to show behaviour problems and are being followed up.

6. The impression gained from this survey is that most if not all the defects of clinical importance revealed by sweep audiometry could—at least in the case of the junior children—have been brought to light by enquiry directed to the presence of E.N.T. abnormality or hearing defect, followed by clinical investigation and audiometry where necessary. In the absence of such enquiry (or in its absence, of routine audiometry) it is likely that a proportion of E.N.T. defective children requiring observation or treatment will escape detection. This, incidentally, emphasizes the shortcomings of the present system of school medical supervision in which children are routinely inspected only once during the intermediate years of their school life. The introduction of improved arrangements to ensure reasonable continuity of health supervision during school life would it is thought make routine audiometry during this period unnecessary.

7. As to the five year olds—the school entrants—it is not possible to draw definite conclusions as to the necessity for routine audiometry on the results of this survey other than to say that the procedure is clearly of value in the detection, not only of hearing defects but of E.N.T. disease which has resulted temporarily or permanently in some degree of hearing loss. In theory there is a good case, because a history of deafness arising from local or other causes such as acute otitis media or constitutional disease in early life or congenital defect is less readily obtainable by enquiry at this early age and the child has not been long enough at school for the effects of hearing loss to become apparent. On the other hand of 229 five year olds tested in this survey, only 6 of 22 failures, compared with 7 of 16 failures in the case of the junior school children, showed no clinical evidence of associated E.N.T. abnormality ; of these, three appeared to be normal in all respects and three showed behaviour problems whose investigation will in any case include a full audiometric examination."

TABLE I

	Ages		Total
	5 years	*7-10 years*	*children*
Tested	229	207	436
Failed first test	43	26	69
Retested	37	21	58
Failed second test	16	11	27

TABLE II

	Ages		Total
	5 years	*7-10 years*	*children*
Failed test twice	16	11	27
Failed test once, not retested	6	5	11
Total	22	16	38
Clinical history with or without physical signs	12	7	19
Physical signs only, no history	3	1	4
No history or physical signs	6	7	13
Not clinically examined	1	1	2

Dr. J. Harkness, School Medical Officer, reports :—

" During the autumn of 1958 routine audiometry was carried out on five-year-old school-children in rural schools in the Halstead area. The sound intensity used was 20 decibels and the frequencies 500, 1000, 2000, 4000 and 6000 cycles per second. Each ear was separately tested and the criteria of failure was inability to hear at more than one frequency in each ear. The children who failed were re-tested after a lapse of a few weeks, and some have not yet been re-tested. The results are summarised in the table set out below :—

Schools	*Tested*	*Failed*	*Failed Retest*	*Referred to E.N.T. Clinic*
Bulmer	17	4	—	—
Pebmarsh	5	1	—	—
Castle Hedingham	15	—	—	—
Belchamp St. Pauls	10	—	—	—
Toppesfield	21	—	—	—
Sible Hedingham	20	3	1	1
Ridgewell	3	—	—	—
Great Yeldham	7	—	—	—
Foxearth	7	—	—	—
Gosfield	10	1	1	1
TOTAL	115	9	2	2

The two children who failed the second test and were referred to the Ear, Nose and Throat Clinic were examined auriscopically and no reason for the deafness was seen. Neither of them had any history of ear, nose or throat disease. Both of the children were thought by their teachers and parents to be rather deaf.

The number of sessions spent on this work cannot be accurately assessed, as in the smaller schools testing was done after the routine school inspections, but approximately six sessions were spent on the work. I do not consider that more than 20 children can be seen in a session if the necessary time to get an accurate assessment of their hearing is to be spent.

In conclusion, I do not consider that in this area routine audiometry is justified, but the same result could be achieved by encouraging the teachers to refer any children about whom they are doubtful to the Minor Ailment Clinic. For this purpose it is necessary for each Medical Officer to have the occasional use of the pure tone audiometer for the accurate assessment of each case which is referred."

Suspected of having a hearing defect and referred for special testing	*Number Tested*		*Number Failed*		*Referred to E.N.T. Surgeon*	*Of those Referred to E.N.T.*				*Found to have normal hearing*
	Barking	*Walthamstow*	*Barking*	*Walthamstow*		*Provided with Hearing Aid*	*Recommended Special Consideration in Class*	*Treatment resulting in normal hearing*	*Still under investigation*	
5 to 6 year olds	32	19 = 51	6	4 = 10	10 =	—	3	3	4	—
7 to 11 year olds	75	172 = 247	15	16 = 31	30 =	2	14	5	5	4
11 to 15 year olds	107	128 = 235	15	17 = 32	29 =	—	12	3	10	4
TOTALS		533		73	69	2	29	11	19	8

Up to 31st December 1958 of the 533 children aged 5 to 15 given special audiometric tests, 61 were found to require treatment as follows :—

Hearing Aids	2	7.8 per cent of children tested. (19 still under investigation).
Special consideration in class	29	
Treatment with return to normal hearing	11	

APPENDIX G

Distribution of treatment of pupils at Child Guidance Clinics 1958

	North-East	*Mid*	*South-East (since February)*	*South*	*Forest (since April)*	*Romford*	*Ilford*	*Walt-hamstow*	*Total*
Psychiatrist									
Special diagnostic cases	10	40	6	15	—	19	9	31	130
Treatment cases	48	92	62	33	25	161	60	96	377
Supervision cases	121	106	—	43	8	46	80	55	459
Awaiting treatment	15	10	33	—	7	—	—	—	65
Psychotherapist									
Treatment cases	28	38	—	31	4	10	62	44	217
Awaiting treatment	1	2		13	5	4	27	—	52
Psychiatric social worker									
Cases advised	179	205	36	147	99	221	395	356	1,638
Cases awaiting advice	32	—	3	—	8	11	—	—	54
Educational psychologist									
Remedial education	16	10	5	8	6	19	16	22	102
Awaiting remedial education	2	2	17	—	1	—	—	—	22

Results of referrals to Child Guidance Clinics 1958

	North-East	*Mid*	*South-East (since February)*	*South*	*Forest (since April)*	*Romford*	*Ilford*	*Walthamstow*	*Total*
Cases awaiting diagnosis January 1st	24	60	—	22	—	46	43	155	350
Cases referred to Clinic during 1958	138	248	183	144	97	273	152	248	1,483
	162	308	183	166	97	319	195	403	1,833
Cases awaiting diagnosis 31st December, 1958, i.e., cases dealt with during 1958	38	33	68	19	17	66	62	94	397
	124	275	115	147	80	253	133	309	1,436
New cases diagnosed during the year and found not to require specific treatment	8	51	8	12	14	20	9	14	136
Cases kept under supervision	32	86	8	17	8	—	12	15	178
New cases diagnosed and which received specific treatment during the year :									
At the clinic	38	69	54	28	32	124	44	97	486
By placement in residential school	4	8	—	6	2	1	15	9	45
New cases diagnosed and awaiting specific treatment :									
At the clinic	18	14	40	13	12	4	27	—	128
By placement in residential school	4	4	5	10	4	5	8	—	40
Cases still under investigation or closed	20	43	—	61	8	99	18	174	423
	124	275	115	147	80	253	133	309	1,436

APPENDIX H

Report of Dr. H. M. S. Davidson, Consultant Psychiatrist at the Ilford Child Guidance Clinic.

"Though we are called a Child Guidance Clinic we are essentially a Family Clinic, our patients are members of a family where personalities react on each other and where problems are closely inter-related.

Children are sent to us through many sources :—School Teacher, Medical Officer, General Practitioner, Hospitals and Clinics, Children's Officer, Probation Officer, or the parents or guardians of the child themselves. They come because someone is worried, either the child who is anxious and fearful, or the parent or teacher who is faced with behaviour they do not like but are unable to modify.

The gradual transition from the stage of early childhood where impulses and emotions are strong and egotistic and self control is weak, to that of the adult, socially responsible, good citizen is a difficult one.

It requires a secure background with loving parents who can supply the child's needs for emotional as well as physical satisfaction and control him while his own self control is yet weak, and give him those standards and ideals through personal example which the child will eventually make his own.

Since parents and children vary in their needs and capacities in carrying out this task, the sources of maladjustment are legion. Minor difficulties abound, as all parents know. Most of them are temporary. It is in overcoming them that parents and children gain in mutual understanding and capacity to deal with difficulties in life. But sometimes they do not clear up and may get worse ; then the whole machinery of family relationships is in danger of being thrown out of gear and the child's whole development may be endangered.

The child reacts to this situation of stress in one or two ways ;

(1) He reacts **actively,** e.g. with persistent temper tantrums, aggresive and destructive, or other forms of anti-social behaviour ; with a persistence of babyhood habits, thumb-sucking, etc., wetting, soiling, etc.; With nervous symptoms such as tics, nail biting or other compulsive habits ; with psychomatic disturbances such as asthma attacks, etc., or

(2) He reacts **passively.** He is timid and fearful of everything ; he reverts to babyishness and immaturity, feels he can do nothing right so refuses to attempt anything ; fails to learn at school though he is of normal intelligence ; fails to adjust socially and cannot make friends.

Many children present quite severe problems in their homes yet may function quite normally at school. Others may be outwardly conforming at school but release the pent up feelings relating to school with increased intensity when they return home. Most teachers now recognise the over-good child as a disturbed child who is afraid to be natural.

Diagnostic Survey.

When children are brought to us, we need to know as much as possible about them and the family set-up and background. We make use of whatever records are available from the School Medical Officer, Family Doctor, Health Visitor, and the schools he has attended.

The parents first come (fathers as well if they can) and are seen by the Psychiatric Social Worker who takes a full social history. This includes the problem for which they attend, its onset, duration, and also a full life history of the child's development, his personality and his interests ; his relationships to his parents and brothers and sisters and theirs to him ; the family background, housing and material conditions and the various anxieties and stresses through which the family has passed. The parents' own history of their childhood is important. The way they handle their children will depend very largely on how they were treated themselves and what their relationships were with their families. It is their own past sufferings and problems, rather than "the sins of the parents" which are visited upon the children and much of the work with parents here is helping them to understand and sort this out.

If the child is old enough and willing enough to separate from his parents, he is seen by the Educational Psychologist while the mother is seeing the Psychiatric Social Worker, and is given a series of tests, not only to assess his intellectual capacity but to gauge his attitude to learning. Some children show particular types of learning difficulties, e.g. in reading, which may indicate a need for special help. The parents and child are then asked to attend for an interview with the Psychiatrist who already has the reports of the first interviews.

The child is usually seen first in the playroom with toys where the Psychiatrist attempts to form a friendly relationship and observe the child's behaviour and reactions with playing material and offers to help him with his problems. Most children, even three year olds, are quite willing to admit that they have worries and usually express their willingness to come again for further help.

The Psychiatrist then sees the parent or parents and discusses the child's problems and possible ways of dealing with them, though final decisions about this may need to be postponed till the case conference has taken place.

A case conference between the Psychiatrist, Psychiatric Social Workers and Educational Psychologists, and attended by the Child Therapists, who may take the child on for treatment, is then held. In some of the cases, the problem is largely a social or material one ; in others an educational measure may be needed ; in some the mother needs help and counselling in her handling of the child ; but in a large proportion of cases, the child needs to attend for weekly treatment while the mother sees the Psychiatric Social Worker.

These diagnostic interviews are very time consuming but are nevertheless essential.

It was stated recently in a medical journal that under the National Health Service, a doctor talks and the patients listens whilst in private practice the patient talks and the doctor listens. In this respect, all our patients are largely private patients. It is what they say and how they say it that gives us the data on which we make our diagnosis.

In a full diagnostic survey at least three people are involved, each spending an hour and a half on every case and there are often additional interviews as well as the case conference.

Treatment.

Our decision about the type of treatment and its probable duration rests largely on whether the problem when referred to us is still an external one or whether it has become internalised within the child's own personality.

In the small child of pre-school age most problems are external and present a conflict between him and his mother, or father, or brother or sister. Often help for the mother with or without the child, may clear up the problem in a small number of interviews.

Another type of external problem for which we can give considerable assistance is in helping the child to adjust psychologically to some traumatic but unavoidable happening :—a severe physical handicap, an injury such as the loss of a leg, the death, or mental or physical illness, of a parent.

We can also help to prepare a child for the birth of a brother or sister, for going to school or going to hospital in cases where the parents recognise that the child will have considerable difficulty.

In older children too, problems are usually external at first but are too often left untreated until they have become internalised and reappear as neurotic symptoms. They are then much less accessible to external help and to changed attitudes in the family and need prolonged psychotherapy to cure them.

To give an example, all children feel jealous of younger brothers and sisters though they may not show it openly and have some difficulty in coming to terms with it and developing a satisfactory fraternal relationship where a competitive spirit is mutually helpful. Some children fail in this task, especially if they are made to feel too guilty over their jealousy and may repress the whole struggle, only to show it later in an internalised form when they fail in all competitive situations. If their conscience forbids them to have any feelings of rivals they may fail at school and elsewhere whenever such feelings tend to be aroused. The neurotic symptoms which we see are these inhibitions of learning or making friends, fears of all types, anxiety states, chronic depressive symptoms with persistent crying and many others.

In these children with largely internalised problems the Psychiatrist or Child Therapist takes them on for weekly treatment of ¾ hour for an average period of eighteen months, though difficult cases may take longer. Those with externalised problems need a shorter period of treatment. The Therapist's aim in these interviews is to establish a relationship with the child which will enable the child to work out his own problems and thereby to cope more adequately with his other relationships so that as an adult he may become a socially responsible good citizen.

The child's parent, mother or father, is also seen by the Psychiatric Social Worker for ¾ hour each week and, through the establishment of an accepting relationship, helps to understand and modify her or his attitudes towards herself or himself and the child.

In addition to regular treatment sessions our Staff are frequently called upon, both personally and by telephone, for discussion or advice on many different problems. Many families still need some support and the opportunity to come and talk over new problems as they arise after we have finished treatment. The parents of those children in boarding schools for Maladjusted Children continue to need help and are seen regularly by the Staff."

APPENDIX I

Incidence of Educationally Sub-Normal Pupils in Divisons

Division	*School Population*	*No. of E.S.N. children requiring special educational treatment*	*Percentage of school population*	*Equivalent wholetime medical officers approved for ascertainment*
North East	27,051	157	.58	4.14
Mid Essex ..	32,003	149	.47	3.7
South East	24,716	156	.63	3.4
South	47,868	236	.49	5.7
Forest	38,523	190	.48	3.4
Romford	22,448	105	.46	3.0
Dagenham	20,659	216	1.04	3.0
Barking	12,485	46	.36	3.8
Ilford	23,720	101	.42	1.5
Leyton	12,870	95	.73	2.8
Walthamstow	19,457	165	.84	1.6

APPENDIX J

MINOR AILMENT CLINICS

NORTH-EAST ESSEX DIVISION :

School Clinic, Trinity Street, Colchester	Mondays to Fridays p.m.	
Essex County Health Services Clinic, 38 Main Road, Harwich	Tuesdays and Fridays a.m.	
Essex County Health Services Clinic, Colchester Road, Halstead	Wednesdays a.m.	
Sible Hedingham Secondary School, Sible Hedingham	Thursdays a.m. (during school term)	
Essex County Health Services Clinic, 31 Skelmersdale Road, Clacton-on-Sea	Monday p.m.	
New Church Schoolroom, Brightlingsea	Wednesdays p.m.	In conjunction with C.W.C's.
Great Bentley Village Hall, Great Bentley	4th Friday p.m.	

MID-ESSEX DIVISION :

Essex County Health Services Clinic, Coggeshall Road, Braintree	Tuesdays 10.0 a.m.
Essex County Health Services Clinic, Crouch Road, Burnham-on-Crouch	2nd Monday 10.0 a.m.
Essex County Health Services Clinic, Coval Lane, Chelmsford	Every Monday 9.30 a.m.
Essex County Health Services Clinic, Wantz Chase, Maldon	1st, 3rd and 5th Friday 10.0 a.m.
Congregational Church Hall, Ongar	2nd and 4th Thursday 2.0 p.m.
Essex County Health Services Clinic, 69 High Street, Saffron Walden	Thursdays 10.0 a.m.
Central Hall, Stanstead	2nd Thursday 9.30 a.m.
Essex County Health Services Clinic, Guithavon Street, Witham	1st and 3rd Thursday, 9.30 a.m.
Essex County Health Services Clinic, 58 New Street, Dunmow	2nd, 4th and 5th Monday 10.0 a.m.

SOUTH-EAST ESSEX DIVISION :

Health Services Clinic, Great Wakering	Fridays a.m.
Health Services Clinic, Rocheway, Rochford	Tuesdays a.m.
Health Services Clinic, Eastwood Road, Rayleigh	Tuesdays and alternate Saturdays a.m.
Health Services Clinic, Kenneth Road, Thundersley	Thursdays a.m.
Health Services Clinic, Nevedon Road Wickford	Mondays a.m.
Health Services Clinic, High Road, Pitsea	Mondays a.m.
Health Services Clinic, Florence Road, Laindon	Fridays a.m.

SOUTH-EAST ESSEX DIVISION—contd.

Health Services Clinic, Laindon Road, Billericay	Thursdays a.m.
Health Services Clinic, Furtherwick Road, Canvey Island	Mondays a.m.
Health Services Clinic, High Road, South Benfleet	Thursdays 10.45 a.m.
Health Services Clinic, Craylands, Timberlog Lane, Basildon	Fridays and Saturdays a.m.
Health Services Clinic, London Road, Hadleigh	Fridays a.m.
Public Hall, Hockley	2nd and 4th Wednesdays a.m.
Health Services Clinic, 119 Honeypot Lane, Basildon	Thursdays a.m.

SOUTH ESSEX DIVISION :

Essex County Health Services Clinic, 38 Queen's Road, Brentwood	Wednesdays a.m.
Essex County Health Services Clinic, Westland Avenue, Hornchurch	Tuesdays and Thursdays a.m.
Essex County Health Services Clinic Abbs Cross Lane, Hornchurch	Thursdays a.m.
Essex County Health Services Clinic, 61 Athelstan Road, Harold Wood	2nd and 4th Fridays only a.m.
Essex County Health Services Clinic, Upminster Road, Rainham	Mondays and Thursdays a.m.
Essex County Health Services Clinic, 230 St. Mary's Lane, Upminster	Wednesdays a.m.
Essex County Health Services Clinic, Glasson House, High Street, Grays	Wednesdays a.m.
Essex County Health Services Clinic, Newton Road. Tilbury	Mondays and Fridays a.m.
St. Margaret's Hall, Corringham Road, Stanford-le-Hope	Mondays and Thursdays a.m.
Village Hall, North Road, South Ockendon, Nr. Grays	Mondays a.m.
Essex County Health Services Clinic, Stifford Long Lane, Grays	Thursdays a.m.
Essex County Health Services Clinic, River View, Chadwell St. Mary	Tuesdays a.m.
Aveley Health Centre, Darenth Lane, South Ockendon	Tuesdays and Fridays a.m.
Essex County Health Services Clinic, South End Road, South Hornchurch, Rainham	Mondays and Thursdays a.m.
Essex County Health Services Clinic, Hall Road, Aveley, Purfleet	Fridays a.m.
Essex County Health Services Clinic, London Road, Purfleet	1st Wednesdays p.m.
Three Arch Bridge Health Services Clinic, Cherry Avenue, Brentwood	Tuesdays a.m.
Essex County Health Services Clinic, Rheidovale, Princess Margaret Road, East Tilbury	1st, 3rd and 5th Thursdays a.m.

FOREST DIVISION :

Essex County Health Services Clinic, Manford Way, Chigwell	Alternate Thursdays a.m.
Essex County Health Services Clinic, Hatch Lane, Chingford	1st, 2nd and 4th Mondays p.m.
Essex County Health Services Clinic, Marmion Avenue, Chingford	Mondays a.m.
Essex County Health Services Clinic, 15 Regent Road, Epping	1st and 3rd Tuesdays a.m.
Addison House, Fourth Avenue, Harlow	Alternate Fridays a.m.
Nuffield House, The Stow, Harlow	Alternate Fridays a.m.
Essex County Health Services Clinic, Loughton Hall, Rectory Lane, Loughton	Thursdays a.m.
Essex County Health Services Clinic, The Cedars, Sewardstone Road, Waltham Abbey	2nd and 4th Tuesdays a.m.
School Clinic, 93 High Road, South Woodford	Fridays a.m.

ROMFORD DIVISION :

Essex County Health Services Clinic, Hulse Avenue, Collier Row	Mondays a.m.
Parklands School	Thursdays a.m.
Hilldene School	Tuesdays a.m.
Essex County Health Services Clinic, Marks Road	Saturdays a.m.
Harold Hill Health Centre, Gooshays Drive, Harold Hill	Mondays and Tuesdays a.m.

BARKING DIVISION :

Central Cinic, Vicarage Drive, Ripple Road, Barking	Each morning
Porters Avenue Clinic, Porters Avenue, Dagenham	Each Morning
Woodward Clinic, Woodward Road, Dagenham	Each Morning
Upney Clinic, Upney Lane, Barking	Each Morning

DAGENHAM DIVISION :

Five Elms School	Mondays p.m. and Fridays a.m.
Essex County Health Services Clinic, Becontree Avenue	Mondays and Thursdays a.m.
Essex County Health Services Clinic, Ballards Road	Mondays p.m.
Essex County Health Services Clinic, Ashton Gardens, Chadwell Health	Tuesdays a.m.
Essex County Health Services Clinic, Ford Road	Mondays a.m. and Thursdays p.m.
Kings Wood School, Harbourer Road, Hainault	Mondays 9.30 a.m. and 1st and 3rd in month
Essex County Health Services Clinic, Oxlow Lane	Wednesdays 9.30 a.m.

ILFORD DIVISION :

Newbury Hall, Perryman's Farm Road, Newbury Park	*Tuesdays and Fridays a.m.
Essex County Health Service Clinic, Goodmayes Lane, Goodmayes	Wednesdays and Fridays a.m.

* As from 1st December, 1958, the Tuesday clinic at Newbury Hall was dispensed with and is now held at Public Health Offices, Valentines Mansion, Emerson Road, Ilford on the same morning.

The Tuesday and Wednesday clinics above mentioned are combined with Immunisation Clinics.

LEYTON DIVISION :

Essex County Health Services Clinic, Granleigh Road, Leytonstone, E.11	Daily a.m. including alternate Saturdays
Essex County Health Services Clinic, Leyton Green Road, Leyton	Daily a.m. including Saturdays
Essex County Health Services Clinic, Dawlish Road, Leyton	Daily a.m. including alternate Saturdays

WALTHAMSTOW DIVISION :

Town Hall	Mondays, Wednesdays, Fridays and Saturdays a.m.
Essex County Health Services Clinic, Silverdale Road, Highams Park	Tuesdays a.m.
Essex County Health Services Clinic, Low Hall Lane, Markhouse Road	Mondays and Thursdays a.m.

SPECIALIST CLINIC

Type of Clinic	*No. of Sessions Monthly*	*Name of Specialist*
North-East Essex Division :		
Ophthalmic	22	Dr. H. S. Sweet
Orthopaedic	$1\frac{2}{3}$	Mr. D. M. Dunn.
Physical Medicine	16	Dr. K. W. Nichols Palmer
Ear, Nose and Throat	1	Mr. J. M. Green
Mid-Essex Division :		
Ophthalmic	23	Dr. A. H. Staples Dr. A. G. Fox Dr. J. J. Reilly Dr. H. S. Sweet Mr. Foulds
Orthopaedic	14	Mr. H. A. H. Harris Mr. D. M. Dunn Mr. R. W. Butler

Type of Clinic	*No. of Sessions Monthly*	*Name of Specialist*
South-East Essex Division :		
Ophthalmic	16	Dr. G. T. Foster-Smith Dr. B. C. Dench
South Essex Division :		
Ophthalmic	29	Dr. G. F. Foster-Smith Dr. H. J. Thorne Dr. J. J. Regal Dr. G. R. Bhatia Dr. D. E. Hone Dr. M. Cripps
Orthopaedic	1	Mr. G. Barclay
Forest Division :		
Ophthalmic	22	Dr. G. Searle Dr. A. D. Fox Dr. G. F. Ensor Dr. J. J. Reilly
Orthopaedic	5	Mr. H. G. Korvin Mr. G. R. Fisk Mr. M. Mason Mr. G. Rigby-Jones
Romford Division :		
Ophthalmic	8	Dr. B. G. Dias Dr. D. E. Hone Dr. J. J. Regal
Orthopaedic	2	Mr. G. Barclay Mr. A. M. A. Moore
Barking Division :		
Dermatology	2	Dr. P. Deville
Ear, Nose and Throat	4	Miss M. Mason
Ophthalmic	16	Dr. R. F. Jamieson
Orthopaedic	2	Mr. Leon Gillis
Paediatric	2	Dr. T. Savage
Dagenham Division :		
Orthopaedic	1	Mr. A. M. A. Moore
Ophthalmic	8	Dr. J. Regal Dr. H. Macfarlane
Ilford Division :		
Orthopaedic	7	Mr. M. Mason Mr. H. G. Korvin

Type of Clinic	*No. of Sessions Monthly*	*Name of Specialist*
Ilford Division—contd.		
Ophthalmic	17	Dr. M. H. Malik Dr. H. J. Thorne Dr. J. J. Reilly
Ear, Nose and Throat	4	Miss M. M. Mason
Paediatric	2	Dr. A. Russell
Cerebral Palsy Unit	2	Dr. D. L. Woolf
Leyton Division:		
Ear, Nose and Throat	1	Dr. D. V. Furlong
Ophthalmic	8	Dr. Logan Adams
Orthopaedic	4	Mr. H. A. Oatley
Walthamstow Division:		
Ear, Nose and Throat	4	Dr. A. Cammock
Ophthalmic	20	Dr. H. Ho
Paediatric	2	Dr. E. Hinden
Orthopaedic	1	Mr. G. Rigby-Jones

CHILD GUIDANCE CLINICS

NORTH-EAST ESSEX DIVISION

Winsley House, High Street, Colchester Population served—27,051	Mondays, Tuesday and Wednesdays a.m. and p.m.

Staff

Psychiatrists	Dr. H. N. Davy (Medical Director). Dr. S. M. Whitteridge.
Educational Psychologist	Mr. A. F. Ward.
Psychiatric Social Workers	Miss K. G. John. Mrs. R. Ellwood.
Child Psychotherapist	Mr. G. Doron.
Remedial Teacher	Mrs. Lamonby.

MID-ESSEX DIVISION

146 Broomfield Road, Chelmsford Population served—38,003	Mondays, Tuesdays and Fridays a.m. and p.m. and Thursdays a.m.

MID-ESSEX DIVISION—contd.

Staff

Psychiatrists	Dr. J. E. G. Vincenzi (Medical Director). Dr. Janet W. Calder.
Educational Psychologist	Miss G. E. Falk.
Psychiatric Social Workers	Mrs. H. M. Thresh. Miss M. G. Lake.
Child Psychotherapist	Mr. J. W. Anderson.

SOUTH-EAST ESSEX DIVISION

119 and 121 Honeypot Lane, Basildon Population served—24,716	Tuesdays a.m. and p.m.

Staff

Psychiatrist	Dr. Joseph N. Runes (Medical Director).
Educational Psychologist	Mr. E. C. Hopkins.
Psychiatric Social Worker	Mrs. D. M. Langley.

SOUTH ESSEX DIVISION

Whitehall Lodge, Whitehall Lane, Grays Population served—41,868	Tuesdays a.m. and p.m.

Staff

Psychiatrists	Dr. R. D. Newton (Medical Director). Dr. L. Bates (locum).
Educational Psychologist	Miss E. A. Bonniface.
Child Psychotherapist	Mrs. I. Seglow.

FOREST DIVISION

Galen House, Town Centre, Harlow Population served—12,130	Mondays and Fridays a.m. and p.m.

Staff

Psychiatrist	Dr. A. C. R. Skynner (Medical Director).
Educational Psychologist	Mrs. Salaman.
Psychiatric Social Worker	Mrs. Marsden.
Child Psychotherapist	Dr. B. Rosenblatt.

ROMFORD DIVISION

62 Western Road, Romford Population served—43,107	Wednesdays a.m. and p.m. and Thursdays a.m.

Staff

Psychiatrists	Dr. J. E. G. Vincenzi (Medical Director). Dr. J. Calder.
Educational Psychologist	Miss I. A. Poulton.
Psychiatric Social Workers	Mrs. C. M. Hadley. Miss M. G. Lake. Mrs. I. T. England.
Child Psychotherapists	Mrs. E. M. Anderson. Mr. H. W. Edwards.

ILFORD DIVISION

Loxford Hall, Loxford Lane, Ilford Population served—36,205	Mondays, Tuesdays and Fridays a.m. and p.m. and Wednesdays p.m.

Staff

Psychiatrists	Dr. Hilda M. Davidson (Medical Director). Dr. H. J. Altschulova.
Educational Psychologists	Miss B. S. Gascoigne. Mrs. Leibowitz.
Psychiatric Social Workers	Miss J. M. Barton. Miss P. Radford.
Child Psychotherapists	Miss R. Oppenhiemer. Miss L. Folkart.

WALTHAMSTOW DIVISION

263 High Street, Walthamstow, E.17 Population served—58,720	Mondays, Tuesdays, Wednesdays a.m. and p.m. and Fridays a.m.

Staff

Psychiatrists	Dr. Helen Gillespie (Medical Director). Dr. H. R. Gurassa.
Educational Psychologists	Miss A. M. Marshall. Miss E. M. Smith.
Psychiatric Social Workers	Miss M. Russel. Miss A. M. Laquer. Miss J. Court.
Child Psychotherapists	Miss H. F. Carr. Miss L. Folkart. Mrs. K. Barker. Miss S. Low-Beer.